

117TH CONGRESS  
2D SESSION

# H. R. 7258

To eliminate the individual and employer health coverage mandates under the Patient Protection and Affordable Care Act, to expand beyond that Act the choices in obtaining and financing affordable health insurance coverage, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 28, 2022

Mr. SESSIONS introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To eliminate the individual and employer health coverage mandates under the Patient Protection and Affordable Care Act, to expand beyond that Act the choices in obtaining and financing affordable health insurance coverage, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; PURPOSES; TABLE OF CON-**  
4 **TENTS.**

5 (a) SHORT TITLE.—This Act may be cited as the  
6 “Health Care Equality and Modernization Act of 2022”.

1 (b) PURPOSES.—The purposes of this Act are as fol-  
 2 lows:

3 (1) ELIMINATION OF INDIVIDUAL AND EM-  
 4 PLOYER MANDATES UNDER ACA.—To eliminate man-  
 5 dates on individuals and employers, and other tax  
 6 requirements, imposed under Patient Protection and  
 7 Affordable Care Act.

8 (2) PROVIDING STATES WITH ALTERNATIVE,  
 9 AFFORDABLE COVERAGE OPTIONS.—To provide  
 10 greater flexibility in providing States with options in  
 11 making affordable health insurance coverage avail-  
 12 able by eliminating certain mandates under PPACA,  
 13 while retaining essential consumer protections, by  
 14 promoting health savings accounts to pay for such  
 15 coverage and long-term care coverage, while permit-  
 16 ting States to continue coverage as provided under  
 17 PPACA.

18 (c) TABLE OF CONTENTS.—The table of contents of  
 19 this Act is as follows:

Sec. 1. Short title; purposes; table of contents.  
 Sec. 2. Definitions.

#### TITLE I—REVISIONS OF PPACA

##### Subtitle A—Elimination of Employer Mandate

Sec. 101. Repeal of employer health insurance mandate.  
 Sec. 102. Clarifying employer's ability to reimburse employee premiums for  
 purchase of individual health insurance coverage.

##### Subtitle B—Limitation on Application of PPACA Plan Requirements

Sec. 121. Limiting application of requirements to consumer protections.

Sec. 122. Offering of basic health insurance; protection of assets from liability or attachment or seizure.

Subtitle C—Health Insurance Tax Benefit

Sec. 131. Health insurance tax benefit.

Sec. 132. Application of portion of unused tax credits by States for indigent health care.

Sec. 133. Medicaid option of enrollment under private plan and contribution to an HSA.

Sec. 134. Repeal of reporting requirements relating to employee health insurance premiums and health plan benefits.

TITLE II—IMPROVING HEALTH SAVINGS ACCOUNTS TO PROMOTE ACCOUNTABILITY

Sec. 201. Transition to non-deductible HSAs.

Sec. 202. Elimination of medical expense deduction.

Sec. 203. Treatment of HSA after death of account beneficiary.

Sec. 204. Treatment of concierge medicine.

TITLE III—STATE FLEXIBILITY IN REGULATION OF HEALTH INSURANCE COVERAGE

Sec. 301. State flexibility in regulation of health insurance coverage.

TITLE IV—MEDICAID PAYMENT REFORM

Sec. 401. Medicaid payment reform.

TITLE V—INCREASING PRICE TRANSPARENCY AND FREEDOM OF PRACTICE

Sec. 501. Publishing of cash price for care paid through health savings accounts.

Sec. 502. Liberating the local practice of health care.

**1 SEC. 2. DEFINITIONS.**

2 Except as otherwise provided, in this Act:

3 (1) BASIC HEALTH INSURANCE.—The term  
4 “basic health insurance” is defined in section  
5 122(a).

6 (2) DEFAULT HEALTH INSURANCE COV-  
7 ERAGE.—The term “default health insurance cov-  
8 erage” is defined in section 121(b)(4)(B).

9 (3) EXCHANGE.—The term “Exchange” means  
10 an Exchange established under title I of PPACA.

1           (4) HEALTH INSURANCE COVERAGE; GROUP  
 2 HEALTH PLAN, ETC.—The terms defined in section  
 3 2791 of the Public Health Service Act, including  
 4 “health insurance coverage”, “group health plan”  
 5 “individual market”, shall apply.

6           (5) LIMITED BENEFIT INSURANCE.—The term  
 7 “limited benefit insurance” is defined in section  
 8 122(b).

9           (6) PPACA.—The term “PPACA” means the  
 10 Patient Protection and Affordable Care Act (Public  
 11 Law 111–148).

12           (7) SECRETARY.—The term “Secretary” means  
 13 the Secretary of Health and Human Services.

14           (8) STATE.—The term “State” includes the  
 15 District of Columbia, Puerto Rico, the United States  
 16 Virgin Islands, American Samoa, Guam, and the  
 17 Northern Mariana Islands.

18       **TITLE I—REVISIONS OF PPACA**  
 19           **Subtitle A—Elimination of**  
 20           **Employer Mandate**

21       **SEC. 101. REPEAL OF EMPLOYER HEALTH INSURANCE MAN-**  
 22           **DATE.**

23           (a) IN GENERAL.—Chapter 43 of the Internal Rev-  
 24 enue Code of 1986 is amended—

25           (1) by striking section 4980H, and

1           (2) by striking the item relating to section  
2       4980H from the table of sections for such chapter.

3       (b) REPEAL OF RELATED REPORTING REQUIRE-  
4 MENTS.—Subpart D of part III of subchapter A of chap-  
5 ter 61 of such Code is amended by striking section 6056  
6 and by striking the item relating to section 6056 in the  
7 table of sections for such subpart.

8       (c) CONFORMING AMENDMENTS.—

9           (1) Section 6724(d)(1)(B) of such Code is  
10 amended—

11               (A) by inserting “or” at the end of clause  
12               (xxiii);

13               (B) by striking “, or” at the end of clause  
14               (xxiv) and inserting a period; and

15               (C) by striking clause (xxv).

16           (2) Section 6724(d)(2) of such Code is amend-  
17 ed by inserting “or” at the end of subparagraph  
18 (FF), by striking “, or” at the end of subparagraph  
19 (GG) and inserting a period, and by striking sub-  
20 paragraph (HH).

21           (3) Section 1513 of the Patient Protection and  
22 Affordable Care Act is amended by striking sub-  
23 section (c).

24       (d) EFFECTIVE DATES.—

1           (1) IN GENERAL.—Except as otherwise pro-  
 2       vided in this subsection, the amendments made by  
 3       this section shall apply to months and other periods  
 4       beginning more than 30 days after the date of the  
 5       enactment of this Act.

6           (2) REPEAL OF STUDY AND REPORT.—The  
 7       amendment made by subsection (c)(3) shall take ef-  
 8       fect on the date of the enactment of this Act.

9   **SEC. 102. CLARIFYING EMPLOYER'S ABILITY TO REIM-**  
 10                   **BURSE EMPLOYEE PREMIUMS FOR PUR-**  
 11                   **CHASE OF INDIVIDUAL HEALTH INSURANCE**  
 12                   **COVERAGE.**

13       An employer health care arrangement, such as a  
 14       health or medical reimbursement arrangement (HRA) or  
 15       other employment plans, under which an employer reim-  
 16       burses an employee for the premiums for the purchase of  
 17       individual health insurance coverage does not constitute  
 18       a group health plan for any purposes, including for pur-  
 19       poses of applying any of the following:

20           (1) The Public Health Service Act (including  
 21       sections 2711 and 2714 of such Act, 42 U.S.C.  
 22       300gg–11, 300gg–14).

23           (2) The Patient Protection and Affordable Care  
 24       Act.

25           (3) The Internal Revenue Code of 1986.

1           (4) The Employee Retirement Income Security  
2       Act of 1974.

3           (5) The HIPAA privacy regulations (as defined  
4       in section 1180(b)(3) of the Social Security Act, 42  
5       U.S.C. 1320d–9(b)(3)).

6           (6) The Health Insurance Portability and Ac-  
7       countability Act of 1996.

8           (7) COBRA continuation coverage under title  
9       XXII of the Public Health Service Act (42 U.S.C.  
10      300bb–1 et seq.), section 4980B of the Internal Rev-  
11      enue Code of 1986, or title VI of the Employee Re-  
12      tirement Income Security Act of 1974 (29 U.S.C.  
13      1161 et seq.).

14   **Subtitle B—Limitation on Applica-**  
15   **tion of PPACA Plan Require-**  
16   **ments**

17   **SEC. 121. LIMITING APPLICATION OF REQUIREMENTS TO**  
18   **CONSUMER PROTECTIONS.**

19       (a) REMOVAL OF PPACA PLAN REQUIREMENTS,  
20   OTHER THAN CERTAIN CONSUMER PROTECTIONS.—

21           (1) IN GENERAL.—Notwithstanding any other  
22      provision of law, with respect to group health plans  
23      and health insurance coverage whether or not of-  
24      fered through an Exchange, except as provided in  
25      paragraphs (2) and (3), the provisions of title

1 XXVII of the Public Health Service Act (42 U.S.C.  
2 300gg et seq.) as in effect on the day before the date  
3 of the enactment of PPACA shall apply instead of  
4 the provisions of such title as in effect after such  
5 date.

6 (2) PPACA CONSUMER PROTECTIONS CON-  
7 TINUING TO BE APPLIED.—The following sections of  
8 the Public Health Service Act, that were added or  
9 amended by subtitles A and C of title I of PPACA,  
10 shall continue to apply to group health plans and to  
11 health insurance coverage offered in the individual  
12 and group market:

13 (A) NO LIFETIME OR ANNUAL LIMITS.—  
14 Section 2711 (42 U.S.C. 300gg–11; relating to  
15 no lifetime or annual limits), except in the case  
16 of limited benefit insurance (as defined in sec-  
17 tion 122(b)).

18 (B) DEPENDENT COVERAGE THROUGH  
19 AGE 26.—Section 2714 (42 U.S.C. 300bb–14;  
20 relating to extension of dependent coverage).

21 (C) MODIFIED GUARANTEED AVAIL-  
22 ABILITY.—Section 2702 (42 U.S.C. 300gg–1;  
23 relating to guaranteed availability of coverage),  
24 subject to paragraph (3) and subsection (c).



1 (D) GUARANTEED RENEWABILITY.—Sec-  
2 tion 2703 (42 U.S.C. 300gg-2; relating to  
3 guaranteed renewability of coverage).

4 (E) PROHIBITING PRE-EXISTING CONDI-  
5 TION EXCLUSIONS.—Section 2704 (42 U.S.C.  
6 300gg-3; relating to prohibition on preexisting  
7 conditions).

8 (F) PROHIBITING DISCRIMINATION BASED  
9 ON HEALTH STATUS.—Section 2705 (42 U.S.C.  
10 300gg-4; relating to prohibiting discrimination  
11 against individual participants and beneficiaries  
12 based on health status), subject to subsection  
13 (c).

14 (G) NON-DISCRIMINATION IN HEALTH  
15 CARE.—Section 2706 (42 U.S.C. 300gg-5; re-  
16 lating to non-discrimination in health care).

17 (3) APPLICATION OF A LATE ENROLLMENT  
18 PENALTY FOR THOSE WITHOUT CONTINUOUS COV-  
19 ERAGE.—

20 (A) IN GENERAL.—In the case of an indi-  
21 vidual who seeks to enroll in health insurance  
22 coverage and who, as of the effective date of  
23 such enrollment, does not have a continuous pe-  
24 riod of at least 12 months of creditable cov-  
25 erage, there shall be imposed a late enrollment

1 penalty in the form of an increase in the  
2 monthly premiums for coverage of under the  
3 plan of 20 percent of the monthly premium oth-  
4 erwise determined for each consecutive full 12-  
5 month period (ending before such effective  
6 date) in which the individual was not enrolled  
7 in creditable coverage. Such increase shall apply  
8 during a period, to be specified under regula-  
9 tions of the Secretary but in no case longer  
10 than 3 times the length of the most recent pe-  
11 riod in which the individual did not have contin-  
12 uous coverage.

13 (B) STATE WAIVER.—A State may apply  
14 to the Secretary for a waiver of the provisions  
15 of subparagraph (A) and the application of al-  
16 ternative provisions providing incentives for  
17 State residents to enroll in creditable coverage  
18 and maintain continuous creditable coverage.  
19 The Secretary shall approve such waiver if the  
20 Secretary determines that the alternative provi-  
21 sions provide similar or greater incentives for  
22 such enrollment than the incentives otherwise  
23 applicable.

1           (4) COORDINATING IMPLEMENTATION OF PRE-  
2       PPACA PHSA PROVISIONS WITH PPACA CONSUMER  
3       PROTECTIONS.—

4           (A) IN GENERAL.—In applying this sub-  
5       section, the provisions described in paragraph  
6       (2) shall be treated as if they were included in  
7       title XXVII of the Public Health Service Act,  
8       as in effect before the date of the enactment of  
9       PPACA, and, with respect to group health  
10      plans and health insurance coverage offered in  
11      connection with such plans, in part 7 of subtitle  
12      B of title I of the Employee Retirement and In-  
13      come Security Act of 1974 (29 U.S.C. 1181 et  
14      seq.), and, with respect to group health plans,  
15      in chapter 100 of the Internal Revenue Code of  
16      1986 as follows:

17           (i) LIFETIME LIMITS; DEPENDENT  
18      COVERAGE.—The provisions described in  
19      paragraphs (2)(A) and (2)(B) shall be  
20      treated as included—

21           (I) with respect to group health  
22      plans (and health insurance coverage  
23      offered with respect to such plans),  
24      under subpart 2 of part A of title  
25      XXVII of the Public Health Service

1 Act (42 U.S.C. 300gg–11 et seq.) and  
2 subpart B of part 7 of subtitle B of  
3 title I of the Employee Retirement  
4 and Income Security Act of 1974 (29  
5 U.S.C. 1181 et seq.);

6 (II) also with respect to group  
7 health plans, under subchapter B of  
8 chapter 100 of the Internal Revenue  
9 Code of 1986; and

10 (III) with respect to individual  
11 health insurance coverage, under sub-  
12 part 2 of part B of title XXVII of the  
13 Public Health Service Act (42 U.S.C.  
14 300gg–15 et seq.).

15 (ii) REMAINING PROVISIONS.—The  
16 provision described in paragraph (2) (other  
17 than in subparagraph (A) or (B) of such  
18 paragraph) shall be treated as included—

19 (I) with respect to group health  
20 plans (and health insurance coverage  
21 offered with respect to such plans),  
22 under subpart 1 of part A of title  
23 XXVII of the Public Health Service  
24 Act (42 U.S.C. 300gg et seq.) and  
25 subpart A of part 7 of subtitle B of

1 title I of the Employee Retirement  
2 and Income Security Act of 1974 (29  
3 U.S.C. 1181 et seq.);

4 (II) also with respect to group  
5 health plans, under subchapter A of  
6 chapter 100 of the Internal Revenue  
7 Code of 1986; and

8 (III) with respect to individual  
9 health insurance coverage, under sub-  
10 part 1 of part B of title XXVII of the  
11 Public Health Service Act (42 U.S.C.  
12 300gg-41 et seq.).

13 (B) CONFLICTING PROVISIONS.—In the  
14 case described in paragraph (1) where there is  
15 a conflict between a provision described in para-  
16 graph (2) and a provision of law described in  
17 paragraph (1), the provision described in para-  
18 graph (2) shall control and the Secretary, in  
19 consultation with the Secretary of the Treasury  
20 and the Secretary of Labor, shall establish such  
21 rules as may be necessary to carry out this sub-  
22 paragraph.

23 (5) CONFORMING AMENDMENTS.—

1 (A) ERISA.—Section 715 of the Employee  
2 Retirement Income Security Act of 1974 (29  
3 U.S.C. 1185d) is amended—

4 (i) in subsection (a), by striking “sub-  
5 section (b)” and inserting “subsections (b)  
6 and (c)”; and

7 (ii) by adding at the end the following  
8 new subsection:

9 “(c) ADDITIONAL EXCEPTION.—Pursuant to section  
10 121 of the Health Care Equality and Modernization Act  
11 of 2022, the provisions of part A of title XXVII of the  
12 Public Health Service Act referred to in subsection (a),  
13 other than those provisions specified in section 121(a)(2)  
14 of the Health Care Equality and Modernization Act of  
15 2022, shall not apply to plans and coverage described in  
16 subsection (a), whether or not the plans or coverage are  
17 offered through an Exchange established under the Pa-  
18 tient Protection and Affordable Care Act.”.

19 (B) IRC.—Section 9815 of the Internal  
20 Revenue Code of 1986 is amended—

21 (i) in subsection (a), by striking “sub-  
22 section (b)” and inserting “subsections (b)  
23 and (c)”; and

24 (ii) by adding at the end the following  
25 new subsection:

1       “(c) ADDITIONAL EXCEPTION.—Pursuant to section  
2 121 of the Health Care Equality and Modernization Act  
3 of 2022, the provisions of part A of title XXVII of the  
4 Public Health Service Act referred to in subsection (a),  
5 other than those provisions specified in section 121(a)(2)  
6 of the Health Care Equality and Modernization Act of  
7 2022, shall not apply to plans described in subsection  
8 (a).”.

9       (b) STATE FLEXIBILITY IN ENSURING ORDERLY  
10 HEALTH INSURANCE MARKET OUTSIDE OF AN EX-  
11 CHANGE.—

12           (1) IN GENERAL.—With respect to health insur-  
13       ance coverage offered in a State, the State may, in  
14       consultation with the Secretary, take such steps,  
15       such as limiting the availability of general open en-  
16       rollment periods, imposing delays in the effectiveness  
17       for coverage, permitting differentials in premiums  
18       based on age and other factors, as the State deter-  
19       mines necessary in order to ensure an orderly mar-  
20       ket for health insurance coverage in the State that  
21       is not offered through an Exchange. Such steps may  
22       include the establishment of such initial open enroll-  
23       ment period during which qualified residents may  
24       enroll in health insurance coverage without the im-  
25       position of any underwriting as the State determines

1 to be appropriate in ensuring initial access to such  
2 coverage.

3 (2) FLEXIBILITY IN IMPOSING ADDITIONAL RE-  
4 QUIREMENTS.—Subject to paragraph (5), nothing in  
5 this section shall be construed as preventing a State  
6 from continuing to apply, to health insurance cov-  
7 erage issued in the State, requirements under the  
8 provisions of title XXVII of the Public Health Serv-  
9 ice Act (as amended by subtitles A and C of title I  
10 of PPACA) that are not continued under subsection  
11 (a).

12 (3) STATE FLEXIBILITY WITH RESPECT TO EX-  
13 CHANGES.—A State may waive such provisions of  
14 part II of subtitle D of title I of PPACA (42 U.S.C.  
15 18031 et seq.), in relation to the establishment of an  
16 Exchange in such State, as the State determines ap-  
17 propriate in order for the State to implement and  
18 administer a market-based system for the avail-  
19 ability of health insurance coverage throughout the  
20 State.

21 (4) STATE DEFAULT ENROLLMENT OPTION.—

22 (A) ENROLLMENT, SUBJECT TO INDIVIDUAL  
23 OPT-OUT.—Subject to subparagraph  
24 (D), a State may elect to provide for the enroll-  
25 ment of residents of the State who are unin-



1           sured in default health insurance coverage (as  
2           defined in subparagraph (B)) and establishing a  
3           Roth HSA for such residents who do not have  
4           a Roth HSA unless the resident has affirma-  
5           tively elected not to be so enrolled and not to  
6           have such an account. respectively. If a State  
7           makes such an election, the State shall permit  
8           eligible residents to enroll in such coverage on  
9           a continuous basis.

10           (B) DEFAULT HEALTH INSURANCE COV-  
11           ERAGE DEFINED.—In this paragraph, the term  
12           “default health insurance coverage” means,  
13           with respect to a State, health insurance cov-  
14           erage that—

15                   (i) is a high deductible health plan  
16                   (within the meaning of section 223(c)(2) of  
17                   the Internal Revenue Code of 1986) with  
18                   prescription drug coverage limited to ge-  
19                   neric drugs for a limited number of chronic  
20                   conditions (commonly referred to as tier I  
21                   pharmacy benefit);

22                   (ii) meets such requirements as may  
23                   apply to qualify for the payment of plan  
24                   premiums from a health savings account  
25                   under section 223 of such Code (such as

1 age-related premiums and limitation on  
2 imposition of preexisting condition exclu-  
3 sions);

4 (iii) has a provider network for cov-  
5 ered benefits that is adequate (as deter-  
6 mined consistent with guidelines issued by  
7 the Secretary) to ensure access to health  
8 benefits under such plan;

9 (iv) provides for coverage of childhood  
10 immunizations without cost sharing re-  
11 quirements to the extent such immuniza-  
12 tions have in effect a recommendation  
13 from the Advisory Committee on Immuni-  
14 zation Practices of the Centers for Disease  
15 Control and Prevention with respect to the  
16 individual involved; and

17 (v) meets such other requirements as  
18 the State may specify.

19 (C) ROTH HSA.—In this paragraph, the  
20 term “Roth HSA” shall have the meaning given  
21 such term by section 530A(c) of the Internal  
22 Revenue Code of 1986, as added by section  
23 201(a) of this Act.

24 (D) SIMPLE PROCESS FOR INDIVIDUALS TO  
25 OPT-OUT.—As a condition of a State providing

1 for the enrollment function described in sub-  
2 paragraph (A), the State must establish an  
3 easy-to-use and transparent means by which in-  
4 dividuals may elect not to be enrolled in default  
5 health insurance coverage or to have a Roth  
6 HSA established on the individual's behalf, or  
7 both.

8 (5) MINIMUM AGE VARIATION PERMITTED FOR  
9 PREMIUM RATES.—With respect to the premium rate  
10 charged by a health insurance issuer for health in-  
11 surance coverage offered in the individual or small  
12 group market, a State may not limit the variation by  
13 age in such rate with respect to a particular plan or  
14 coverage involved by less than a factor of 5 to 1 for  
15 adults. The previous sentence shall be treated as if  
16 it were included in subpart I of part A of title  
17 XXVII of the Public Health Service Act (42 U.S.C.  
18 300gg et seq.).

19 (c) INAPPLICABILITY OF REQUIRED ESSENTIAL  
20 HEALTH BENEFITS.—

21 (1) IN GENERAL.—Notwithstanding any other  
22 provision of law, no health benefits plan shall be re-  
23 quired by reason of Federal law to comply with the  
24 requirements of sections 1301(a)(1)(B) and 1302 of  
25 PPACA (42 U.S.C. 18021(a)(1)(B), 18022).

1           (2) STATE FLEXIBILITY.—Nothing in this sub-  
2       section shall be construed as preventing a State  
3       from applying, at its option with respect to health  
4       insurance coverage offered through an Exchange or  
5       otherwise in the State, the requirements referred to  
6       in paragraph (1).

7       (d) EFFECTIVE DATE; TRANSITION.—

8           (1) IN GENERAL.—Subsections (a), (b), and (c)  
9       shall apply to plan years beginning after the date of  
10      the enactment of this Act.

11          (2) SUNSETTING REQUIRED CONTRIBUTION FOR  
12      ACA REINSURANCE PROGRAM.—No contribution shall  
13      be required under section 1341 of PPACA (42  
14      U.S.C. 18061) from any group health plan or health  
15      insurance issuer for portions of plans years occur-  
16      ring in months beginning more than 30 days after  
17      the date of the enactment of this Act.

18      (e) SECRETARIAL GUIDANCE.—The Secretary of  
19      Health and Human Services, in coordination with the Sec-  
20      retary of Labor and the Secretary of the Treasury, shall  
21      provide such guidance as may be necessary for the coordi-  
22      nated implementation of this section on a timely basis.

23      (f) TRANSFERRING HEALTH PLAN RECORDS UPON  
24      CHANGING PLANS.—

1           (1) IN GENERAL.—In the case of an individual  
2           who is covered under health insurance coverage or as  
3           a beneficiary or participant in a group health plan  
4           (as such terms are defined in section 2791 of the  
5           Public Health Service Act, 42 U.S.C. 300gg–91), if  
6           such coverage is ended and the individual obtains  
7           other health insurance coverage, group health plan  
8           coverage, or other creditable coverage (as defined for  
9           purposes of title XXVII of such Act), the issuer of  
10          the prior coverage or administrator of the prior plan  
11          shall forward information respecting such prior cov-  
12          erage to the issuer of the new coverage or adminis-  
13          trator of the new plan or coverage, as the case may  
14          be, subject to such rules as the Secretary establishes  
15          regarding the right of the beneficiary or participant  
16          to object to such forwarding of information.

17          (2) TREATMENT AS PLAN REQUIREMENT  
18          UNDER PHSA, ERISA, IRC.—The requirement of  
19          paragraph (1) shall apply as if it were a section  
20          under part A of title XXVII of the Public Health  
21          Service Act, including for purposes of applying sec-  
22          tion 715 of the Employee Retirement Income Secu-  
23          rity Act of 1976 (29 U.S.C. 1185d) and section  
24          9815 of the Internal Revenue Code of 1986.

25          (g) APPLICATION OF RISK ADJUSTMENT.—

1           (1) IN GENERAL.—Any issuer that offers health  
2       insurance coverage in the individual market in any  
3       of the 50 States or the District of Columbia shall  
4       participate in a risk adjustment mechanism under  
5       this subsection with respect to any health insurance  
6       coverage it so offers in such market, whether or not  
7       such coverage is offered through an Exchange.

8           (2) FORM AND DESIGN OF RISK ADJUSTMENT  
9       MECHANISM.—The Secretary shall, in consultation  
10      with the National Association of Insurance Commis-  
11      sioners and other interested parties, develop a mech-  
12      anism to permit the adjustment of risk among  
13      health insurance coverage offered in the individual  
14      market throughout the 50 States and the District of  
15      Columbia. Such mechanism shall be designed to ef-  
16      fect the same type of risk adjustment among such  
17      coverage that is applicable to risk adjustment of  
18      payments among Medicare Advantage organizations  
19      under part C of title XVIII of the Social Security  
20      Act (42 U.S.C. 1395w–21 et seq.).

21          (3) TRANSITION FOR NEW COVERAGE.—The  
22      mechanism developed under paragraph (2) shall pro-  
23      vide for transitional protection, over a 3-year period,  
24      in the case of health insurance coverage that has not  
25      been previously marketed.

1           (4) DEVELOPMENT OF FURTHER RISK ADJUST-  
 2           MENT MECHANISM.—The Secretary shall request the  
 3           National Association of Insurance Commissioners to  
 4           develop a permanent model for adjustment of risk  
 5           among health insurance issuers with respect to  
 6           health insurance coverage offered in the individual  
 7           market, with the intention that such a model would  
 8           substitute for the mechanism developed under para-  
 9           graph (2).

10          (5) TREATMENT AS PLAN REQUIREMENT  
 11          UNDER PHSA, ERISA, IRC.—The requirement of  
 12          paragraph (1) shall apply as if it were a section  
 13          under part A of title XXVII of the Public Health  
 14          Service Act (42 U.S.C. 300gg et seq.), including for  
 15          purposes of applying section 715 of the Employee  
 16          Retirement Income Security Act of 1976 (29 U.S.C.  
 17          1185d) and section 9815 of the Internal Revenue  
 18          Code of 1986.

19 **SEC. 122. OFFERING OF BASIC HEALTH INSURANCE; PRO-**  
 20 **TECTION OF ASSETS FROM LIABILITY OR AT-**  
 21 **TACHMENT OR SEIZURE.**

22          (a) REQUIREMENT FOR EXCHANGES.—

23           (1) IN GENERAL.—No tax credit shall be allow-  
 24           able under section 36B or 36C of the Internal Rev-  
 25           enue Code of 1986 for residents of a State unless

1 any Exchange established in the State provides for  
 2 the offering of basic health insurance in all areas of  
 3 the State.

4 (2) BASIC HEALTH INSURANCE DEFINED.—In  
 5 this subsection, the term “basic health insurance”  
 6 means, with respect to a State, such health insur-  
 7 ance coverage as the State may specify and includes  
 8 limited benefit insurance (as defined in subsection  
 9 (b)).

10 (b) LIMITED BENEFIT INSURANCE DEFINED.—

11 (1) IN GENERAL.—In this title, the term “lim-  
 12 ited benefit insurance” means individual health in-  
 13 surance coverage that, with respect to a plan year,  
 14 imposes (consistent with paragraph (2)) an annual  
 15 limit on the amounts that may be payable under the  
 16 coverage with respect to expenses incurred for items  
 17 and services furnished in that plan year.

18 (2) SPECIFICATION OF ANNUAL LIMIT; VARI-  
 19 ATION IN LIMIT FOR INDIVIDUAL AND FAMILY COV-  
 20 ERAGE.—The Secretary shall specify, from year to  
 21 year, the annual limit (or range of annual limits)  
 22 that may be applied under paragraph (1). Such a  
 23 limit may distinguish between coverage that is only  
 24 provided for an individual and coverage that is pro-  
 25 vided also for family members of the individual.



1       (c) PROTECTION OF CERTAIN ASSETS IN CASE OF  
2 INDIVIDUALS COVERED UNDER LIMITED BENEFIT IN-  
3 SURANCE.—

4           (1) IN GENERAL.—Notwithstanding any other  
5 provision of law, if an individual is covered under  
6 limited benefit insurance for a plan year and bene-  
7 fits under such insurance have reached the annual  
8 limit under such insurance for items and services  
9 furnished in the plan year, the individual is not lia-  
10 ble for debt incurred and arising from the provision  
11 of subsequently furnished items and services during  
12 the plan year, regardless of whether benefits are oth-  
13 erwise covered for such items and services under  
14 such policy, insofar as the liability attributable to  
15 such items and services exceeds—

16           (A) the bankruptcy valuation of the indi-  
17 vidual's property at the time the debt is in-  
18 curred; reduced by

19           (B) such annual limit of benefits under the  
20 limited benefit insurance for the plan year.

21 Property in the amount so protected from liability  
22 shall be exempt and immune from attachment or sei-  
23 zure with respect to any judgment related to such  
24 debt.

1           (2) BANKRUPTCY VALUATION DEFINED.—In  
2       this subsection, the term “bankruptcy valuation”  
3       means, with respect to property of an individual as  
4       of a date, the value of the property as of such date  
5       as determined as if the individual were a debtor in  
6       a bankruptcy case that could have been filed under  
7       title 11 of the United States Code and the property  
8       could not be exempt under section 522 of such title.

9           (3) NO REQUIREMENT FOR PROVIDERS TO FUR-  
10      NISH SUBSEQUENT SERVICES WITHOUT ENSURING  
11      PAYMENT.—Except as may be explicitly provided in  
12      other law (such as under section 1867 of the Social  
13      Security Act, 42 U.S.C. 1395dd; popularly known as  
14      EMTALA), a health care provider is not required to  
15      furnish any items or services to an individual who  
16      has exhausted benefits under limited benefit insur-  
17      ance for a plan year without the individual (or an-  
18      other person on the individual’s behalf) providing for  
19      such advance or guarantee of payment for such  
20      items and services as may be arranged between the  
21      health care provider and the individual.

1     **Subtitle C—Health Insurance Tax**  
2                     **Benefit**

3     **SEC. 131. HEALTH INSURANCE TAX BENEFIT.**

4             (a) IN GENERAL.—Subpart C of part IV of sub-  
5 chapter A of chapter 1 of the Internal Revenue Code of  
6 1986 is amended by inserting after section 36B the fol-  
7 lowing new section:

8     **“SEC. 36C. HEALTH INSURANCE TAX CREDIT.**

9             “(a) IN GENERAL.—In the case of an individual who  
10 is a qualified resident, there shall be allowed as a credit  
11 against the tax imposed by this subtitle for any taxable  
12 year an amount equal to the health credit amount of the  
13 taxpayer for the taxable year.

14            “(b) HEALTH CREDIT AMOUNT.—For purposes of  
15 this section—

16               “(1) IN GENERAL.—The term ‘health credit  
17 amount’ means the sum of the amounts determined  
18 under paragraph (2) with respect to all months of  
19 the taxpayer for the taxable year.

20               “(2) MONTHLY CREDIT AMOUNT.—

21                   “(A) IN GENERAL.—Subject to paragraph  
22 (4), the amount determined under this para-  
23 graph with respect to any month shall be an  
24 amount equal to the sum of—

1 “(i)  $\frac{1}{12}$  of \$2,500 in the case of any  
2 month the first day of which the taxpayer  
3 is a qualified resident and is covered by  
4 creditable coverage (twice such amount in  
5 the case of a joint return if both spouses  
6 are so covered by creditable coverage and  
7 are qualified residents), plus

8 “(ii)  $\frac{1}{12}$  of an amount equal to  
9 \$1,500 multiplied by the number of quali-  
10 fying children (within the meaning of sec-  
11 tion 152) who are qualified residents  
12 and—

13 “(I) for whom the taxpayer is al-  
14 lowed a deduction under section 151  
15 for the taxable year in which such  
16 month ends, and

17 “(II) who are covered by cred-  
18 itable coverage on the first day of  
19 such month.

20 “(B) CARRYFORWARD OF MONTHLY CRED-  
21 IT AMOUNT IN CASE CREDIT AMOUNT EXCEEDS  
22 HSA CONTRIBUTIONS AND PREMIUM PAY-  
23 MENTS.—In the case of any month for which  
24 the credit amount determined with respect to  
25 the taxpayer under subparagraph (A) exceeds

1 the limitation amount determined with respect  
2 to the taxpayer for such month under para-  
3 graph (3), such excess may be carried forward  
4 to any subsequent month during the taxable  
5 year for purposes of determining the credit  
6 amount for such month under this paragraph.

7 “(3) MONTHLY LIMITATION.—

8 “(A) IN GENERAL.—The amount deter-  
9 mined under paragraph (2) for any month of  
10 the taxpayer shall not exceed the sum of—

11 “(i) the amounts contributed to a  
12 health savings account of the taxpayer for  
13 such month, plus

14 “(ii) the premiums paid by the tax-  
15 payer for creditable coverage.

16 “(B) CARRYFORWARD OF MONTHLY LIM-  
17 ITATION IN CASE HSA CONTRIBUTIONS AND PRE-  
18 MIUM PAYMENTS EXCEED MONTHLY CREDIT  
19 AMOUNT.—In the case of any month for which  
20 the amount determined with respect to the tax-  
21 payer under subparagraph (A) exceeds the cred-  
22 it amount determined with respect to the tax-  
23 payer for such month under paragraph (2),  
24 such excess may be carried forward to any sub-  
25 sequent month during the taxable year for pur-

1           poses of determining the limitation under sub-  
2           paragraph (A).

3           “(4) ADJUSTMENT FOR LIMITED BENEFIT IN-  
4           SURANCE.—In the case of a taxpayer whose only  
5           health insurance coverage for a month is limited  
6           benefit insurance (as defined in section 123(b) of the  
7           Health Care Equality and Modernization Act of  
8           2022), the amount determined under paragraph (2)  
9           shall be decreased by such proportion as the Sec-  
10          retary, in consultation with the Secretary of Health  
11          and Human Services, determines appropriate, taking  
12          into account the ratio of the actuarial value of such  
13          limited benefit insurance to the average actuarial  
14          value of health insurance coverage that is not limited  
15          benefit insurance.

16          “(5) ADJUSTMENT FOR GEOGRAPHIC AREA AND  
17          AGE OF COVERED INDIVIDUAL.—The amount deter-  
18          mined under paragraph (2) shall be adjusted, in a  
19          manner specified by the Secretary, in consultation  
20          with and based on data collected by the Secretary of  
21          Health and Human Services, to take into account,  
22          for a taxpayer or other covered individual of an age  
23          and residing in an area, the ratio of the average cost  
24          of typical individual health insurance coverage for an  
25          individual of such age and residing in such area to

1 the national average cost of such typical health in-  
2 surance coverage. Such adjustment shall be made in  
3 a manner so that the application of this paragraph  
4 is estimated not to change the aggregate amount of  
5 the credits allowable under this section for taxable  
6 years ending in a year.

7 “(c) COORDINATION WITH EMPLOYER-PROVIDED  
8 HEALTH INSURANCE TAX SUBSIDY.—

9 “(1) CREDIT LIMITED BY EMPLOYER-PROVIDED  
10 HEALTH INSURANCE TAX SUBSIDY.—The credit al-  
11 lowed under this section for any taxable year shall  
12 not exceed an amount equal to the excess (if any)  
13 of—

14 “(A) the maximum credit which would be  
15 allowed for all months of the taxpayer during  
16 the taxable year (determined under subsection  
17 (b)(2) and without regard to this subsection,  
18 the limitation under subsection (b)(3), and any  
19 reduction under subsection (d)(1)), over

20 “(B) the taxpayer’s employer-provided  
21 health insurance tax subsidy for the taxable  
22 year.

23 “(2) EMPLOYER-PROVIDED HEALTH INSURANCE  
24 TAX SUBSIDY.—For purposes of this subsection—

1           “(A) IN GENERAL.—The term ‘employer-  
2           provided health insurance tax subsidy’ means,  
3           with respect to any taxpayer for a taxable year,  
4           the sum of—

5                   “(i) the Federal income tax subsidy of  
6                   the taxpayer for the taxable year, plus

7                   “(ii) the Federal payroll tax subsidy  
8                   of the taxpayer for the taxable year.

9           “(B) FEDERAL INCOME TAX SUBSIDY.—  
10          The term ‘Federal income tax subsidy’ means,  
11          with respect to any taxpayer for the taxable  
12          year, the excess (if any) of—

13                   “(i) the amount of tax that would  
14                   have been imposed by this chapter for the  
15                   taxable year had such tax been determined  
16                   without regard to this section and by in-  
17                   cluding amounts otherwise excluded from  
18                   gross income which were paid by or on be-  
19                   half of the taxpayer for employer-provided  
20                   insurance that constitutes medical care,  
21                   over

22                   “(ii) the amount of tax imposed by  
23                   this chapter for the taxable year (deter-  
24                   mined without regard to this section).



1           “(C) FEDERAL PAYROLL TAX SUBSIDY.—

2           The term ‘Federal payroll tax subsidy’ means,  
3           with respect to any taxpayer for the taxable  
4           year, the excess (if any) of—

5                   “(i) the sum of—

6                           “(I) the amount of tax that  
7                           would have been imposed by chapter  
8                           21 with respect to any wages of the  
9                           taxpayer paid during the taxable year  
10                          had such tax been determined by in-  
11                          cluding amounts otherwise excluded  
12                          from wages which were paid by or on  
13                          behalf of the taxpayer during the tax-  
14                          able year for employer-provided insur-  
15                          ance that constitutes medical care,  
16                          plus

17                           “(II) the amount of tax that  
18                           would have been imposed by chapter 2  
19                           on any self-employment income of the  
20                           taxpayer for such taxable year had  
21                           self-employment income been deter-  
22                           mined without regard to any deduc-  
23                           tion from gross income for amounts  
24                           paid for insurance which constitutes  
25                           medical care for the taxpayer, the tax-

1 payer's spouse, and any qualifying  
 2 children (within the meaning of sec-  
 3 tion 152) for whom the taxpayer is al-  
 4 lowed a deduction under section 151  
 5 for the taxable year, over

6 “(ii) the amount of tax imposed with  
 7 respect to the taxpayer during such taxable  
 8 year under chapter 21 and for such taxable  
 9 year under chapter 2.

10 “(d) RECONCILIATION OF CREDIT AND ADVANCE  
 11 CREDIT.—

12 “(1) IN GENERAL.—The amount of the credit  
 13 allowed under this section for any taxable year (after  
 14 the application of subsections (b) and (c)) shall be  
 15 reduced (but not below zero) by the amount of any  
 16 advance payment of such credit under subsection  
 17 (e)(1).

18 “(2) EXCESS ADVANCE PAYMENTS.—

19 “(A) IN GENERAL.—If the advance pay-  
 20 ments to a taxpayer under subsection (e)(1) for  
 21 a taxable year exceed the credit allowed by this  
 22 section (determined without regard to para-  
 23 graph (1)), the tax imposed by this chapter for  
 24 the taxable year shall be increased by the  
 25 amount of such excess.

1           “(B) LIMITATION ON INCREASE.—In the  
2           case of a taxpayer whose household income is  
3           less than 400 percent of the poverty line for the  
4           size of the family involved for the taxable year,  
5           the amount of the increase under subparagraph  
6           (A) shall in no event exceed the applicable dol-  
7           lar amount determined in accordance with the  
8           following table (one-half of such amount in the  
9           case of a taxpayer whose tax is determined  
10          under section 1(c) for the taxable year):

<b>“If the household income (expressed as a percent of poverty line) is:</b>	<b>The applicable dollar amount is:</b>
Less than 200% .....	\$600
At least 200% but less than 300% .....	\$1,500
At least 300% but less than 400% .....	\$2,500.

11          “(e) SPECIAL RULES.—For purpose of this section—

12           “(1) ADVANCE PAYMENT PROGRAM.—

13           “(A) IN GENERAL.—The Secretary of the  
14           Treasury, in consultation with the Secretary of  
15           Health and Human Services, shall establish a  
16           program—

17           “(i) to make advance determinations  
18           with respect to the eligibility of individuals  
19           for the credit allowed under this section,  
20           and

1                   “(ii) to make advance payments of the  
2                   credit allowed under this section, at the  
3                   election of any such individual so eligible,  
4                   directly to the health savings account of  
5                   any such individual, or, as a subsidy to the  
6                   cost of health insurance coverage provided  
7                   to any such individual, to the health insur-  
8                   ance issuer providing such coverage or the  
9                   person that administers the plan benefits  
10                  with respect to such coverage.

11               “(B) PROGRAM REQUIREMENTS.—Such  
12               program shall be established under rules similar  
13               to the rules of section 1412 of the Patient Pro-  
14               tection and Affordable Care Act, as in effect on  
15               the day before the date of the enactment of this  
16               section, except that advance determinations and  
17               advance payments shall be made on request of  
18               the individual with respect to whom the deter-  
19               mination is to be made.

20               “(2) INFORMATION REQUIREMENTS.—

21               “(A) IN GENERAL.—Each person providing  
22               health insurance coverage which constitutes  
23               medical care, and each trustee of a health sav-  
24               ings account, shall provide the following infor-

1 mation to the Secretary and to the taxpayer  
2 with respect to such coverage or such account:

3 “(i) The total premium for the cov-  
4 erage without regard to the credit under  
5 this section.

6 “(ii) The aggregate amount of any ad-  
7 vance payment of such credit made with  
8 respect to such coverage or to such ac-  
9 count.

10 “(iii) The name, address, age, and  
11 TIN of the primary insured or account  
12 holder (as the case may be) and the name,  
13 age, and TIN of each other individual ob-  
14 taining coverage under such policy of in-  
15 surance.

16 “(iv) Any information provided to  
17 such person necessary to determine eligi-  
18 bility for, and the amount of, such credit.

19 “(v) Information necessary to deter-  
20 mine whether a taxpayer has received ex-  
21 cess advance payments.

22 “(B) EXCEPTION.—Subparagraph (A)  
23 shall not apply to any coverage with respect to  
24 which reporting under section 6051 is required.

25 “(3) INDEXING.—

“(A) IN GENERAL.—In the case of any calendar year beginning after 2022, each of the dollar amounts in subsection (b)(2) and in the table contained under subsection (d)(2)(B) shall be equal to such dollar amount multiplied by the ratio of—

“(i) the current dollar gross domestic product (as determined based on the third estimate of the Bureau of Economic Analysis of the Department of Commerce for the second quarter of the previous year), to

“(ii) the current dollar gross domestic product (as so determined) for the second quarter of 2021.

“(B) ROUNDING.—If the amount of any change under subparagraph (A) is not a multiple of \$50, such change shall be rounded to the next lowest multiple of \$50.

“(f) DEFINITIONS.—For purposes of this section—

“(1) CREDITABLE COVERAGE.—

“(A) IN GENERAL.—The term ‘creditable coverage’ has the meaning given such term for purposes of title XXVII of the Public Health Service Act. Such term shall not include coverage under any health plan that includes cov-

1           erage for abortions (other than any abortion de-  
2           scribed in subparagraph (B)).

3           “(B) EXCEPTION.—The second sentence of  
4           subparagraph (A) shall not apply to an abor-  
5           tion—

6                   “(i) if the pregnancy is the result of  
7                   an act of rape or incest, or

8                   “(ii) in the case where a woman suf-  
9                   fers from a physical disorder, physical in-  
10                  jury, or physical illness that would, as cer-  
11                  tified by a physician, place the woman in  
12                  danger of death unless an abortion is per-  
13                  formed, including a life-endangering phys-  
14                  ical condition caused by or arising from  
15                  the pregnancy itself.

16           “(C) SEPARATE ABORTION COVERAGE OR  
17           PLAN ALLOWED.—

18                   “(i) OPTION TO PURCHASE SEPARATE  
19                   COVERAGE OR PLAN.—Nothing in subpara-  
20                   graph (A) shall be construed as prohibiting  
21                   any individual from purchasing separate  
22                   coverage for abortions described in such  
23                   subparagraph, or a health plan that in-  
24                   cludes such abortions, so long as no credit

1 is allowed under this section with respect  
 2 to the premiums for such coverage or plan.

3 “(ii) OPTION TO OFFER COVERAGE OR  
 4 PLAN.—Nothing in subparagraph (A) shall  
 5 restrict any non-Federal health insurance  
 6 issuer offering a health plan from offering  
 7 separate coverage for abortions described  
 8 in such subparagraph, or a plan that in-  
 9 cludes such abortions, so long as premiums  
 10 for such separate coverage or plan are not  
 11 paid for with any amount attributable to  
 12 the credit allowed under this section (or  
 13 the amount of any advance payment of the  
 14 credit).

15 “(2) QUALIFIED RESIDENT.—The term ‘quali-  
 16 fied resident’ means an individual who is a citizen or  
 17 national of the United States or otherwise lawfully  
 18 residing in the United States under color of law.”.

19 (b) DISQUALIFICATION FROM EXCHANGE PLAN SUB-  
 20 SIDIES FOR INDIVIDUAL ONCE THEY ELECT TAX BENE-  
 21 FITS.—Section 36B(c)(1) of such Code is amended by  
 22 adding at the end the following new subparagraph:

23 “(E) DENIAL OF CREDIT FOR THOSE  
 24 ELECTING UNIVERSAL CREDIT.—In the case of  
 25 an individual who is allowed a credit under sec-



1           tion 36C for any taxable year, no credit shall be  
2           allowed under this section to such individual for  
3           such taxable year or any subsequent taxable  
4           year.”.

5           (c) GUIDANCE.—The Secretary of the Treasury shall  
6           issue such guidance as is necessary—

7           (1) to assist employees and employers in adjust-  
8           ing Federal income tax withholding to take into ac-  
9           count the health insurance tax credit under section  
10          36C of the Internal Revenue Code of 1986 (and any  
11          advance payment thereof), and

12          (2) to require employers to report to each em-  
13          ployee with respect to periods not longer than quar-  
14          terly the employer-provided health insurance tax  
15          subsidy (as defined in section 36C(c)(2) of such  
16          Code) with respect to such employee for such period.

17          (d) CLERICAL AMENDMENT.—The table of sections  
18          for subpart C of part IV of subchapter A of chapter 1  
19          of the Internal Revenue Code of 1986 is amended by in-  
20          serting after the item relating to section 36B the following  
21          new item:

          “Sec. 36C. Health insurance tax credit.”.

22          (e) EFFECTIVE DATE.—The amendments made by  
23          this section shall apply to taxable years beginning after  
24          December 31, 2021.

1 **SEC. 132. APPLICATION OF PORTION OF UNUSED TAX**  
2 **CREDITS BY STATES FOR INDIGENT HEALTH**  
3 **CARE.**

4 (a) COMPUTATION OF UNUSED CREDITS.—The Sec-  
5 retary, in consultation with the Secretary of the Treasury,  
6 shall calculate for each State for each year, beginning with  
7 2022, using the most recent data available—

8 (1) the maximum aggregate amount of credits  
9 under section 36C of the Internal Revenue Code of  
10 1986 that would have been allowed for the year for  
11 qualified residents of the State for taxable years  
12 ending in the year if all eligible qualified residents  
13 had qualified for such credits;

14 (2) the aggregate amount of credits under such  
15 section that were allowed for taxable years ending in  
16 that the year by qualified residents of such State;  
17 and

18 (3) 25 percent of the amount by which—

19 (A) the amount determined under para-  
20 graph (1) with respect to qualified residents of  
21 the State for such year; exceeds

22 (B) the amount determined under para-  
23 graph (2) for such State for that year.

24 (b) APPROPRIATION.—For the purpose of making  
25 grants to States under this section, there is hereby appro-  
26 priated to the Secretary, out of any funds in the Treasury

1 not otherwise appropriated, for each year (beginning with  
2 2021) an amount equivalent to the amount determined  
3 under subsection (a)(3) for all States under subsection (a)  
4 for the year in which such fiscal year ends, subject to ad-  
5 justment under subsection (d)(2).

6 (c) GRANTS TO STATES FOR INDIGENT ASSIST-  
7 ANCE.—

8 (1) APPLICATION.—A State may file with the  
9 Secretary (in a form and manner specified by the  
10 Secretary) an application to provide assistance in  
11 furnishing health services to indigent individuals re-  
12 siding in the State. Such application shall dem-  
13 onstrate the manner in which such assistance is fur-  
14 nished in an equitable manner to individuals residing  
15 in all parts of the State.

16 (2) AMOUNT OF FUNDS.—From the funds ap-  
17 propriated under subsection (b) for a year, the  
18 amount of funds paid to any State in any year  
19 under this section with an application filed in ac-  
20 cordance with paragraph (1) is equal to an amount  
21 specified in the application, but not to exceed the  
22 amount computed under subsection (a)(3) for the  
23 State and the year.

24 (3) USE OF FUNDS.—Funds paid to a State  
25 under this subsection may be used only to assist in

1 the furnishing of health services to uninsured indi-  
2 viduals residing in the State or for purposes of in-  
3 creasing the payment adjustments made under sec-  
4 tions 1886(d)(5)(F) and 1923 of the Social Security  
5 Act (42 U.S.C. 1395ww(d)(5)(F), 1396r-4) to hos-  
6 pitals that serve a disproportionate share of such in-  
7 dividuals in the State.

8 (d) INITIAL ESTIMATE; FINAL CALCULATION AND  
9 RECONCILIATION.—

10 (1) USE OF ESTIMATES.—The calculations  
11 under subsection (a) for a year shall initially be esti-  
12 mated before the beginning of the year. Payments  
13 under this section to a State for a year shall be  
14 made, subject to reconciliation under paragraph (2),  
15 based on the amount so estimated.

16 (2) RECONCILIATION BASED ON FINAL CAL-  
17 CULATION.—The calculations under subsection (a)  
18 for a year shall also be made after the end of the  
19 year. Insofar as the amount calculated under this  
20 paragraph for subsection (a)(3) for a State for a  
21 year exceeds (or is less than) by a material amount  
22 from the amount for subsection (a)(3) estimated and  
23 applied for the State and year under paragraph (1),  
24 the amount calculated under subsection (a)(3) for  
25 the State for the 2nd year beginning after such year,

1       shall be reduced or increased, respectively by the  
2       amount of such excess or deficit.

3   **SEC. 133. MEDICAID OPTION OF ENROLLMENT UNDER PRI-**  
4                   **VATE PLAN AND CONTRIBUTION TO AN HSA.**

5       (a) IN GENERAL.—Notwithstanding any other provi-  
6       sion of law, a State plan under title XIX of the Social  
7       Security Act (42 U.S.C. 1396 et seq.) may make available  
8       to an individual, who is entitled to medical assistance for  
9       a full range of acute care items and services under such  
10      title and at the individual's option, instead of the medical  
11      assistance otherwise provided, medical assistance con-  
12      sisting of coverage under a health plan that qualifies for  
13      a tax credit under section 36C of the Internal Revenue  
14      Code of 1986, but only if the State provides for the indi-  
15      vidual medical assistance, in the form of a deposit into  
16      a health savings account for the individual, an amount  
17      equivalent to the amount by which the amount of tax cred-  
18      it for the individual under such section exceeds the cost  
19      of coverage of the individual under the plan.

20      (b) FFP TREATMENT.—The payments by a State de-  
21      scribed in subsection (a) for coverage under a health plan  
22      and for deposit into a health savings account shall be  
23      treated as medical assistance for purposes of section 1903  
24      of the Social Security Act (42 U.S.C. 1396b) and subject  
25      to Federal financial participating, including the applica-

tion of State matching payments, in the same manner as other medical assistance furnished under title XIX of such Act, except that such amount shall be reduced by the amount of any health insurance credits provided under section 36C of the Internal Revenue Code of 1986 with respect to such coverage or deposit.

**SEC. 134. REPEAL OF REPORTING REQUIREMENTS RELATING TO EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.**

(a) REPORTING REQUIREMENTS.—Section 6051(a) of such Code is amended by striking paragraph (14) and by redesignating paragraphs (15), (16), and (17) as paragraphs (14), (15), and (16), respectively.

(b) EFFECTIVE DATES.—The amendment made by this section shall apply to calendar years beginning after December 31, 2018.

**TITLE II—IMPROVING HEALTH SAVINGS ACCOUNTS TO PROMOTE ACCOUNTABILITY**

**SEC. 201. TRANSITION TO NON-DEDUCTIBLE HSAS.**

(a) NON-DEDUCTIBLE HSAS.—Subchapter F of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following new part:

**“PART IX—HEALTH SAVINGS ACCOUNTS**

“Sec. 530A. Roth HSAs.

1   **“SEC. 530A. ROTH HSAS.**

2           “(a) IN GENERAL.—A Roth HSA shall be exempt  
3 from taxation under this subtitle. Notwithstanding the  
4 preceding sentence, the Roth HSA shall be subject to the  
5 taxes imposed by section 511 (relating to imposition of  
6 tax on unrelated business income of charitable organiza-  
7 tions). No deduction shall be allowed for any contribution  
8 to a Roth HSA.

9           “(b) DOLLAR LIMITATION.—

10           “(1) IN GENERAL.—The aggregate amount of  
11 contributions for any taxable year to all Roth HSAs  
12 maintained for the benefit of an individual shall not  
13 exceed the sum of the monthly limitations for month  
14 during such taxable year that the individual is an el-  
15 igible individual.

16           “(2) MONTHLY LIMITATION.—The monthly lim-  
17 itation for any month is  $\frac{1}{12}$  of—

18           “(A) in the case of an eligible individual  
19 who has self-only creditable coverage as of the  
20 first day of such month, \$5,000, and

21           “(B) in the case of an eligible individual  
22 who has family creditable coverage as of the  
23 first day of such month, the amount in effect  
24 under subparagraph (A) for the taxable year  
25 multiplied by the number of individuals (includ-

1           ing the eligible individual) covered under such  
2           family creditable coverage as of such day.

3           “(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—In the case of an individual  
4           who has attained age 55 before the close of the taxable  
5           year, the applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by \$1,000.  
6             
7             
8           

9           “(4) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this  
10          paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not  
11          below zero) by the sum of—  
12            
13          

14               “(A) the aggregate amount paid for such  
15               taxable year to Archer MSAs of such individual,

16               “(B) the aggregate amount contributed to  
17               Roth HSAs of such individual which is excludable from the taxpayer’s gross income for such  
18               taxable year under section 106(d) (and such amount shall not be allowed as a deduction  
19               under subsection (a)), and  
20                 
21               

22               “(C) the aggregate amount contributed to  
23               Roth HSAs of such individual for such taxable  
24               year under section 408(d)(9) (and such amount



1           shall not be allowed as a deduction under sub-  
2           section (a)).

3           Subparagraph (A) shall not apply with respect to  
4           any individual to whom paragraph (5) applies.

5           “(5) SPECIAL RULE FOR MARRIED INDIVID-  
6           UALS.—In the case of individuals who are married  
7           to each other, if either spouse has family coverage—

8                   “(A) both spouses shall be treated as hav-  
9                   ing only such family coverage (and if such  
10                  spouses each have family coverage under dif-  
11                  ferent plans, as having the family coverage with  
12                  the lowest annual deductible), and

13                  “(B) the limitation under paragraph (1)  
14                  (after the application of subparagraph (A) and  
15                  without regard to any additional contribution  
16                  amount under paragraph (3))—

17                          “(i) shall be reduced by the aggregate  
18                          amount paid to Archer MSAs of such  
19                          spouses for the taxable year, and

20                          “(ii) after such reduction, shall be di-  
21                          vided equally between them unless they  
22                          agree on a different division.

23           “(6) DENIAL OF DEDUCTION TO DEPEND-  
24           ENTS.—No contribution may be made to a Roth  
25           HSA under this section by any individual with re-

1       spect to whom a deduction under section 151 is al-  
2       lowable to another taxpayer for a taxable year begin-  
3       ning in the calendar year in which such individual's  
4       taxable year begins.

5           “(7) MEDICARE ELIGIBLE INDIVIDUALS.—The  
6       limitation under this subsection for any month with  
7       respect to an individual shall be zero for the first  
8       month such individual is entitled to benefits under  
9       title XVIII of the Social Security Act and for each  
10      month thereafter.

11          “(8) INCREASE IN LIMIT FOR INDIVIDUALS BE-  
12      COMING ELIGIBLE INDIVIDUALS AFTER THE BEGIN-  
13      NING OF THE YEAR.—

14           “(A) IN GENERAL.—For purposes of com-  
15      puting the limitation under paragraph (1) for  
16      any taxable year, an individual who is an eligi-  
17      ble individual during the last month of such  
18      taxable year shall be treated—

19           “(i) as having been an eligible indi-  
20      vidual during each of the months in such  
21      taxable year, and

22           “(ii) as having been enrolled, during  
23      each of the months such individual is  
24      treated as an eligible individual solely by  
25      reason of clause (i), in the same high de-

ductible health plan in which the individual was enrolled for the last month of such taxable year.

“(B) FAILURE TO MAINTAIN CREDITABLE COVERAGE.—

“(i) IN GENERAL.—If, at any time during the testing period, the individual is not an eligible individual, then—

“(I) gross income of the individual for the taxable year in which occurs the first month in the testing period for which such individual is not an eligible individual is increased by the aggregate amount of all contributions to the Roth HSA of the individual which could not have been made but for subparagraph (A), and

“(II) the tax imposed by this chapter for any taxable year on the individual shall be increased by 10 percent of the amount of such increase.

“(ii) EXCEPTION FOR DISABILITY OR DEATH.—Subclauses (I) and (II) of clause (i) shall not apply if the individual ceased

1 to be an eligible individual by reason of the  
2 death of the individual or the individual  
3 becoming disabled (within the meaning of  
4 section 72(m)(7)).

5 “(iii) TESTING PERIOD.—The term  
6 ‘testing period’ means the period beginning  
7 with the last month of the taxable year re-  
8 ferred to in subparagraph (A) and ending  
9 on the last day of the 12th month fol-  
10 lowing such month.

11 “(c) ROTH HSA.—For purposes of this section—

12 “(1) IN GENERAL.—The term ‘Roth HSA’  
13 means a trust created or organized in the United  
14 States as a Roth HSA exclusively for the purpose of  
15 paying the qualified medical expenses of the account  
16 beneficiary, but only if the written governing instru-  
17 ment creating the trust meets the following require-  
18 ments:

19 “(A) Except in the case of a rollover con-  
20 tribution described in subsection (f)(5) or sec-  
21 tion 220(f)(5), no contribution will be accept-  
22 ed—

23 “(i) unless it is in cash, or

24 “(ii) to the extent such contribution,  
25 when added to previous contributions to

1 the trust for the calendar year, exceeds the  
2 sum of—

3 “(I) the dollar amount in effect  
4 under subsection (b)(2)(B), and

5 “(II) the dollar amount in effect  
6 under subsection (b)(3).

7 “(B) The trustee is a bank (as defined in  
8 section 408(n)), an insurance company (as de-  
9 fined in section 816), or another person who  
10 demonstrates to the satisfaction of the Sec-  
11 retary that the manner in which such person  
12 will administer the trust will be consistent with  
13 the requirements of this section.

14 “(C) No part of the trust assets will be in-  
15 vested in life insurance contracts.

16 “(D) The assets of the trust will not be  
17 commingled with other property except in a  
18 common trust fund or common investment  
19 fund.

20 “(E) The interest of an individual in the  
21 balance in his account is nonforfeitable.

22 “(2) QUALIFIED MEDICAL EXPENSES.—For  
23 purposes of this section—

24 “(A) IN GENERAL.—The term ‘qualified  
25 medical expenses’ means, with respect to an ac-

count beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d) as in effect on the day before the date of the enactment of the Health Care Equality and Modernization Act of 2022) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

“(B) LIMITATION ON HEALTH INSURANCE PURCHASED FROM ACCOUNT.—Such term shall not include any payment for health benefits coverage that is not creditable coverage (as defined in section 36C).

“(C) EXCEPTIONS.—Subparagraph (B) shall not apply to any expense for coverage under—

“(i) a health plan during any period of continuation coverage required under any Federal law,

“(ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),

1 “(iii) a health plan during a period in  
2 which the individual is receiving unemploy-  
3 ment compensation under any Federal or  
4 State law, or

5 “(iv) in the case of an account bene-  
6 ficiary who has attained the age specified  
7 in section 1811 of the Social Security Act,  
8 any health insurance other than a medi-  
9 care supplemental policy (as defined in sec-  
10 tion 1882 of the Social Security Act).

11 “(3) ACCOUNT BENEFICIARY.—The term ‘ac-  
12 count beneficiary’ means the individual on whose be-  
13 half the Roth HSA was established.

14 “(4) CERTAIN RULES TO APPLY.—Rules similar  
15 to the following rules shall apply for purposes of this  
16 section:

17 “(A) Section 219(f)(3) (relating to time  
18 when contributions deemed made).

19 “(B) Except as provided in section 106(d),  
20 section 219(f)(5) (relating to employer pay-  
21 ments).

22 “(C) Section 408(g) (relating to commu-  
23 nity property laws).

24 “(D) Section 408(h) (relating to custodial  
25 accounts).

1       “(d) ELIGIBLE INDIVIDUAL; CREDITABLE COV-  
2 ERAGE.—For purposes of this section—

3               “(1) ELIGIBLE INDIVIDUAL.—The term ‘eligible  
4 individual’ means, with respect to any month, any  
5 individual if such individual is covered under cred-  
6 itable coverage as of the first day of such month.

7               “(2) CREDITABLE COVERAGE.—The term ‘cred-  
8 itable coverage’ shall have the meaning given such  
9 term in section 36C(f).

10       “(e) TAX TREATMENT OF DISTRIBUTIONS.—

11               “(1) AMOUNTS USED FOR QUALIFIED MEDICAL  
12 EXPENSES.—Any amount paid or distributed out of  
13 a Roth HSA which is used exclusively to pay quali-  
14 fied medical expenses of any account beneficiary  
15 shall not be includible in gross income.

16               “(2) INCLUSION OF AMOUNTS NOT USED FOR  
17 QUALIFIED MEDICAL EXPENSES.—Any amount paid  
18 or distributed out of a Roth HSA which is not used  
19 exclusively to pay the qualified medical expenses of  
20 the account beneficiary shall be included in the gross  
21 income of such beneficiary.

22               “(3) EXCESS CONTRIBUTIONS RETURNED BE-  
23 FORE DUE DATE OF RETURN.—

24               “(A) IN GENERAL.—If any excess con-  
25 tribution is contributed for a taxable year to



1 any Roth HSA of an individual, paragraph (2)  
2 shall not apply to distributions from the Roth  
3 HSAs of such individual (to the extent such dis-  
4 tributions do not exceed the aggregate excess  
5 contributions to all such accounts of such indi-  
6 vidual for such year) if—

7 “(i) such distribution is received by  
8 the individual on or before the last day  
9 prescribed by law (including extensions of  
10 time) for filing such individual’s return for  
11 such taxable year, and

12 “(ii) such distribution is accompanied  
13 by the amount of net income attributable  
14 to such excess contribution.

15 Any net income described in clause (ii) shall be  
16 included in the gross income of the individual  
17 for the taxable year in which it is received.

18 “(B) EXCESS CONTRIBUTION.—For pur-  
19 poses of subparagraph (A), the term ‘excess  
20 contribution’ means any contribution (other  
21 than a rollover contribution described in para-  
22 graph (5) or section 220(f)(5)) which exceeds  
23 the contribution limitation with respect to the  
24 individual for the taxable year.

1           “(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT  
2       USED FOR QUALIFIED MEDICAL EXPENSES.—

3           “(A) IN GENERAL.—The tax imposed by  
4       this chapter on the account beneficiary for any  
5       taxable year in which there is a payment or dis-  
6       tribution from a Roth HSA of such beneficiary  
7       which is includible in gross income under para-  
8       graph (2) shall be increased by 10 percent of  
9       the amount which is so includible.

10          “(B) EXCEPTION FOR DISABILITY OR  
11       DEATH.—Subparagraph (A) shall not apply if  
12       the payment or distribution is made after the  
13       account beneficiary becomes disabled within the  
14       meaning of section 72(m)(7) or dies.

15          “(C) EXCEPTION FOR DISTRIBUTIONS  
16       AFTER MEDICARE ELIGIBILITY.—Subparagraph  
17       (A) shall not apply to any payment or distribu-  
18       tion after the date on which the account bene-  
19       ficiary attains the age specified in section 1811  
20       of the Social Security Act.

21          “(5) ROLLOVER CONTRIBUTION.—An amount is  
22       described in this paragraph as a rollover contribu-  
23       tion if it meets the requirements of subparagraphs  
24       (A) and (B).

1           “(A) IN GENERAL.—Paragraph (2) shall  
2           not apply to any amount paid or distributed  
3           from a health savings account (as defined in  
4           section 223) or a Roth HSA to the account  
5           beneficiary to the extent the amount received is  
6           paid into a Roth HSA for the benefit of such  
7           beneficiary not later than the 60th day after  
8           the day on which the beneficiary receives the  
9           payment or distribution.

10           “(B) LIMITATION.—This paragraph shall  
11           not apply to any amount described in subpara-  
12           graph (A) received by an individual from a  
13           health savings account or a Roth HSA if, at  
14           any time during the 1-year period ending on the  
15           day of such receipt, such individual received any  
16           other amount described in subparagraph (A)  
17           from a health savings account or Roth HSA  
18           which was not includible in the individual’s  
19           gross income because of the application of this  
20           paragraph.

21           “(6) TRANSFER OF ACCOUNT INCIDENT TO DI-  
22           VORCE.—The transfer of an individual’s interest in  
23           a Roth HSA to an individual’s spouse or former  
24           spouse under a divorce or separation instrument de-  
25           scribed in subparagraph (A) of section 71(b)(2) shall

not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a Roth HSA with respect to which such spouse is the account beneficiary.

“(7) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—If an individual acquires an account beneficiary’s interest in a health savings account by reason of the death of the account beneficiary, such health savings account shall be treated as if the individual were the account beneficiary.

“(f) COST-OF-LIVING ADJUSTMENT.—

“(1) IN GENERAL.—In the case of any calendar year beginning after 2022, the \$5,000 dollar amount in subsection (b)(2) shall be increased by an amount equal to—

“(A) such dollar amount, multiplied by

“(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined—

“(i) by substituting ‘calendar year 2021’ for ‘calendar year 1992’ in subparagraph (B) thereof, and

“(ii) by substituting ‘CPI medical care component’ for ‘CPI’.

1           “(2) CPI MEDICAL CARE COMPONENT.—For  
2       purposes of this paragraph, the term ‘CPI medical  
3       care component’ means the medical care component  
4       for the Consumer Price Index for All Urban Con-  
5       sumers published by the Department of Labor.

6           “(3) ROUNDING.—If the amount of any in-  
7       crease under the preceding sentence is not a mul-  
8       tiple of \$50, such increase shall be rounded to the  
9       next lowest multiple of \$50.

10          “(g) REPORTS.—The Secretary may require—

11               “(1) the trustee of a Roth HSA to make such  
12       reports regarding such account to the Secretary and  
13       to the account beneficiary with respect to contribu-  
14       tions, distributions, the return of excess contribu-  
15       tions, and such other matters as the Secretary deter-  
16       mines appropriate, and

17               “(2) any person who provides an individual with  
18       creditable coverage to make such reports to the Sec-  
19       retary and to the account beneficiary with respect to  
20       such plan as the Secretary determines appropriate.

21       The reports required by this subsection shall be filed at  
22       such time and in such manner and furnished to such indi-  
23       viduals at such time and in such manner as may be re-  
24       quired by the Secretary.”.

1 (b) LIMIT ON CONTRIBUTIONS TO DEDUCTIBLE  
2 HEALTH SAVINGS ACCOUNTS.—Section 223 of such Code  
3 is amended by adding at the end the following new sub-  
4 section:

5 “(i) LIMITED CONTRIBUTIONS AFTER 2021.—

6 “(1) IN GENERAL.—No contribution may be ac-  
7 cepted by a health savings account after December  
8 31, 2021.

9 “(2) EXCEPTIONS.—Paragraph (1) shall not  
10 apply—

11 “(A) in the case of a rollover contribution  
12 described in subsection (f)(5) or section  
13 220(f)(5), or

14 “(B) in the case of a month for which an  
15 individual is covered by insurance that con-  
16 stitutes medical care and that is provided by an  
17 employer with respect to which an election is in  
18 effect for such month under section 131(b) of  
19 the Health Care Equality and Modernization  
20 Act of 2022.”.

21 (c) CLERICAL AMENDMENT.—The table of parts for  
22 subchapter F of chapter 1 of such Code is amended by  
23 adding at the end the following new item:

“PART IX. ROTH HEALTH SAVINGS ACCOUNTS”.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to taxable years beginning after  
3 December 31, 2021.

4 **SEC. 202. ELIMINATION OF MEDICAL EXPENSE DEDUCTION.**

5 Section 213 of the Internal Revenue Code of 1986  
6 is amended by adding at the end the following new sub-  
7 section:

8 “(f) TERMINATION.—Except in the case of long-term  
9 care premiums (as defined in subsection (d)(10)), sub-  
10 section (a) shall not apply to any amounts paid during  
11 any taxable year beginning after December 31, 2021.”.

12 **SEC. 203. TREATMENT OF HSA AFTER DEATH OF ACCOUNT**  
13 **BENEFICIARY.**

14 (a) IN GENERAL.—Section 223(f)(8) of the Internal  
15 Revenue Code of 1986 is amended to read as follows:

16 “(8) TREATMENT AFTER DEATH OF ACCOUNT  
17 BENEFICIARY.—If an individual acquires an account  
18 beneficiary’s interest in a health savings account by  
19 reason of the death of the account beneficiary, such  
20 health savings account shall be treated as if the indi-  
21 vidual were the account beneficiary.”.

22 (b) EFFECTIVE DATE.—The amendment made by  
23 this section shall apply with respect to interests acquired  
24 after the date of the enactment of this Act.

1 **SEC. 204. TREATMENT OF CONCIERGE MEDICINE.**

2 (a) HSAs.—

3 (1) ROTH HSA.—Section 530A(c)(2)(A) of the  
4 Internal Revenue Code of 1986, as added by section  
5 201(a) of this Act, is amended by adding at the end  
6 the following: “Such term shall include the payment  
7 of a monthly or other prepaid amount for the fur-  
8 nishing (or access to the furnishing) by a physician  
9 or group of physicians of physician professional serv-  
10 ices (and ancillary services).”.

11 (2) HSA.—Section 223(d)(2)(A) of such Code  
12 is amended by adding at the end the following: “The  
13 term ‘qualified medical care expenses’ shall include  
14 the payment of a monthly or other prepaid amount  
15 for the furnishing (or access to the furnishing) by a  
16 physician or group of physicians of physician profes-  
17 sional services (and ancillary services).”.

18 (b) NOT TREATED AS HEALTH INSURANCE COV-  
19 ERAGE.—

20 (1) IN GENERAL.—For purposes of title XXVII  
21 of the Public Health Service Act (42 U.S.C. 300gg),  
22 subtitle B of title I of the Employee Retirement and  
23 Income Security Act of 1974 (29 U.S.C. 1021 et  
24 seq.), PPACA, and this Act, the offering of con-  
25 cierge medicine shall not be treated as the offering



1 of health insurance coverage and shall not be subject  
 2 to regulations as such coverage under such Acts.

3 (2) CONCIERGE MEDICINE DEFINED.—In this  
 4 subsection, the term “concierge medicine” means the  
 5 furnishing (or access to the furnishing) by a physi-  
 6 cian or group of physicians of physician professional  
 7 services (and ancillary services) in return for pay-  
 8 ment of a monthly or other prepaid amount.

9 **TITLE III—STATE FLEXIBILITY**  
 10 **IN REGULATION OF HEALTH**  
 11 **INSURANCE COVERAGE**

12 **SEC. 301. STATE FLEXIBILITY IN REGULATION OF HEALTH**  
 13 **INSURANCE COVERAGE.**

14 (a) IN GENERAL.—States are given the flexibility  
 15 under section 122(b) to revise their regulations of the  
 16 health insurance marketplace, without regard to many of  
 17 the requirements imposed under PPACA, in order to pro-  
 18 mote freedom of choice of affordable health insurance cov-  
 19 erage options offered outside of an Exchange.

20 (b) CONSTRUCTION.—Nothing in the Employee Re-  
 21 tirement and Income Security Act of 1974 (29 U.S.C.  
 22 1001 et seq.) or of any amendments made by the Health  
 23 Insurance Portability and Accountability Act of 1996  
 24 (Public Law 104–191) shall be interpreted as preventing  
 25 an employer from offering, or making an employer con-

1   tribution towards, individual health insurance coverage for  
2   employees and dependent family members.

3       (c) ASSOCIATION HEALTH PLANS.—Nothing in this  
4   Act shall be construed as prohibiting the formation of as-  
5   sociation health plans (as defined under State law).

6       (d) HIGH-RISK POOLS.—Nothing in this Act shall be  
7   construed as prohibiting States from establishing pooling  
8   arrangements for high-risk individuals.

## 9       **TITLE IV—MEDICAID PAYMENT** 10                   **REFORM**

### 11   **SEC. 401. MEDICAID PAYMENT REFORM.**

12       (a) IN GENERAL.—Title XIX of the Social Security  
13   Act (42 U.S.C. 1396 et seq.) is amended by inserting after  
14   section 1903 the following section:

#### 15   **“SEC. 1903A. REFORMED PAYMENT TO STATES.**

16       “(a) REFORMED PAYMENT SYSTEM.—

17               “(1) IN GENERAL.—For quarters beginning on  
18       or after the implementation date (as defined in sub-  
19       section (k)(1)), in lieu of amounts otherwise payable  
20       to a State under this title (including any payments  
21       attributable to section 1923), except as otherwise  
22       provided in this section, the amount payable to such  
23       State shall be equal to the sum of the following:

24               “(A)    ADJUSTED    AGGREGATE    BENE-  
25               FICIARY-BASED AMOUNT.—The aggregate bene-

1           ficiary-based amount specified in subsection (b)  
2           for the quarter and the State, adjusted under  
3           subsection (e).

4           “(B) CHRONIC CARE QUALITY BONUS.—  
5           The amount (if any) of the chronic care quality  
6           bonus payment specified in subsection (f) for  
7           the quarter for the State.

8           “(2) REQUIREMENT OF STATE SHARE.—

9           “(A) IN GENERAL.—A State shall make,  
10          from non-Federal funds, expenditures in an  
11          amount equal to its State share (as determined  
12          under subparagraph (B)) for a quarter for  
13          items, services, and other costs for which, but  
14          for paragraph (1), Federal funds would have  
15          been payable under this title.

16          “(B) STATE SHARE.—The State share for  
17          a State for a quarter in a fiscal year is equal  
18          to the product of—

19                 “(i) the aggregate beneficiary-based  
20                 amount specified in subsection (b) for the  
21                 quarter and the State; and

22                 “(ii) the ratio of—

23                         “(I) the State percentage de-  
24                         scribed in subparagraph (D)(ii) for  
25                         such State and fiscal year; to

1 “(II) the Federal percentage de-  
2 scribed in subparagraph (D)(i) for  
3 such State and fiscal year.

4 “(C) NONPAYMENT FOR FAILURE TO PAY  
5 STATE SHARE.—

6 “(i) IN GENERAL.—If a State fails to  
7 expend the amount required under sub-  
8 paragraph (A) for a quarter in a fiscal  
9 year, the amount payable to the State  
10 under paragraph (1) shall be reduced by  
11 the product of the amount by which the  
12 State payment is less than the State share  
13 and the ratio of—

14 “(I) the Federal percentage de-  
15 scribed in subparagraph (D)(i) for  
16 such State and fiscal year; to

17 “(II) the State percentage de-  
18 scribed in subparagraph (D)(ii) for  
19 such State and fiscal year.

20 “(ii) GRACE PERIOD.—A State shall  
21 not be considered to have failed to provide  
22 payment of its required State share for a  
23 quarter under subparagraph (A) if the ag-  
24 gregate State payment towards the State’s  
25 required State share for the 4-quarter pe-

1           riod beginning with such quarter exceeds  
2           the required State share amount for such  
3           4-quarter period.

4           “(D) FEDERAL AND STATE PERCENT-  
5           AGES.—In this paragraph, with respect to a  
6           State and a fiscal year:

7                   “(i) FEDERAL PERCENTAGE.—The  
8                   Federal percentage described in this clause  
9                   is 75 percent or, if higher, the Federal  
10                  medical assistance percentage for such  
11                  State for such fiscal year.

12                  “(ii) STATE PERCENTAGE.—The State  
13                  percentage described in this clause is 100  
14                  percent minus the Federal percentage de-  
15                  scribed in clause (i).

16           “(E) RULES FOR CREDITING TOWARD  
17           STATE SHARE.—

18                   “(i) GENERAL LIMITATION TO MATCH-  
19                   ABLE EXPENDITURES.—A payment for ex-  
20                   penditures shall not be counted toward the  
21                   State share under subparagraph (A) unless  
22                   Federal payments may be used for such  
23                   expenditures consistent with paragraph  
24                   (3)(B).

1           “(ii) FURTHER LIMITATIONS ON AL-  
2           LOWABLE EXPENDITURES.—A payment for  
3           expenditures shall not be counted towards  
4           the State share under subparagraph (A) if  
5           the expenditure is for any of the following:

6                   “(I) ABORTION.—Expenditures  
7                   for an abortion.

8                   “(II) INTERGOVERNMENTAL  
9                   TRANSFERS.—An expenditure that is  
10                  attributable to an intergovernmental  
11                  transfer.

12                  “(III) CERTIFIED PUBLIC EX-  
13                  PENDITURES.—An expenditure that is  
14                  attributable to certified public expend-  
15                  itures.

16           “(iii) CREDITING FRAUD AND ABUSE  
17           RECOVERIES.—Amounts recovered by a  
18           State through the operation of its Medicaid  
19           fraud and abuse control unit described in  
20           section 1903(q) shall be fully counted to-  
21           ward the State share under subparagraph  
22           (A).

23           “(F) CONSTRUCTION.—Nothing in the  
24           paragraph shall be construed as preventing a  
25           State from expending, from non-Federal funds,

1 an amount under this title in excess of the  
2 amount of the State share.

3 “(G) DETERMINATION BASED UPON SUB-  
4 MITTED CLAIMS.—In applying this paragraph  
5 with respect to expenditures of a State for a  
6 quarter, the determination of the expenditures  
7 for such State for such quarter shall be made  
8 after the end of the period (which, as of the  
9 date of the enactment of this section, is 2  
10 years) for which the Secretary accepts claims  
11 for payment under this title with respect to  
12 such quarter.

13 “(3) USE OF FEDERAL PAYMENTS.—

14 “(A) APPLICATION OF MEDICAID LIMITA-  
15 TIONS.—A State may only use Federal pay-  
16 ments received under subsection (a) for expend-  
17 itures for which Federal funds would have been  
18 payable under this title but for this section.

19 “(B) LIMITATION FOR CERTAIN ELIGI-  
20 BLES.—

21 “(i) APPLICATION OF 100 PERCENT  
22 FEDERAL POVERTY LINE LIMIT ON ELIGI-  
23 BILITY.—Subject to clause (iii), a State  
24 may not use such Federal payments to  
25 provide medical assistance for an indi-

vidual who has an income (as determined under clause (ii)) that exceeds 100 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

“(ii) DETERMINATION OF INCOME USING MODIFIED ADJUSTED GROSS INCOME WITHOUT ANY 5 PERCENT INCREASE.—In determining income for purposes of clause (i) under section 1902(e)(14) (relating to modified adjusted gross income), the following rules shall apply:

“(I) APPLICATION OF SPEND DOWN.—The State shall take into account the costs incurred for medical care or for any other type of remedial care recognized under State law in the same manner and to the same extent that such State takes such costs into account for purposes of section 1902(a)(17).

“(II) DISREGARD OF 5 PERCENT INCREASE.—Subparagraph (I) of sec-



1                   tion 1902(e)(14) (relating to a 5 per-  
2                   cent reduction) shall not apply.

3                   “(iii) EXCEPTION.—Clause (i) shall  
4                   not apply to an individual who is—

5                   “(I) a woman described in clause  
6                   (i) of section 1903(v)(4)(A);

7                   “(II) a child who is an individual  
8                   described in clause (i) of section  
9                   1905(a);

10                  “(III) enrolled in a State plan  
11                  under this title as of the date of the  
12                  enactment of this section for the pe-  
13                  riod of continuous enrollment; or

14                  “(IV) described in section  
15                  1902(e)(14)(D) (relating to modified  
16                  adjusted gross income).

17                  “(iv) CLARIFICATION RELATED TO  
18                  COMMUNITY SPOUSE.—Nothing in this  
19                  subparagraph shall supersede the applica-  
20                  tion of section 1924 (related to community  
21                  spouse income and assets).

22                  “(4) EXCEPTIONS FOR PASS-THROUGH PAY-  
23                  MENTS.—

24                  “(A) IN GENERAL.—Paragraph (1) shall  
25                  not apply, and amounts shall continue to be

1 payable under this title (and not under sub-  
2 section (a)), in the case of the following pay-  
3 ments (and related administrative costs and ex-  
4 penditures):

5 “(i) PAYMENTS TO TERRITORIES.—

6 Payments to a State other than the 50  
7 States and the District of Columbia.

8 “(ii) MEDICARE COST SHARING.—

9 Payments attributable to Medicare cost  
10 sharing under section 1905(p).

11 “(iii) PEDIATRIC VACCINES.—Pay-

12 ments attributable to section 1928.

13 “(iv) EMERGENCY SERVICES FOR CER-

14 TAIN INDIVIDUALS.—Payments for treat-  
15 ment of emergency medical conditions at-  
16 tributable to the application of section  
17 1903(v)(2).

18 “(v) INDIAN HEALTH CARE FACILI-

19 TIES.—Payments for medical assistance  
20 described in the third sentence of section  
21 1905(b).

22 “(vi) EMPLOYER-SPONSORED INSUR-

23 ANCE (ESI).—Payments for medical assist-  
24 ance attributable to payments to employers

1 for employer-sponsored health benefits cov-  
2 erage.

3 “(vii) OTHER POPULATIONS WITH  
4 LIMITED BENEFIT COVERAGE.—Other pay-  
5 ments that are determined by the Sec-  
6 retary to be related to a specified popu-  
7 lation for which the medical assistance  
8 under this title is limited and does not in-  
9 clude any inpatient, nursing facility, or  
10 long-term care services.

11 “(B) CERTAIN EXPENSES.—Paragraph (1)  
12 shall not apply, and amounts shall continue to  
13 be payable under this title (and not under sub-  
14 section (a)), in the case of the following:

15 “(i) ADMINISTRATION OF MEDICARE  
16 PRESCRIPTION DRUG BENEFIT.—Expendi-  
17 tures described in section 1935(b) (relating  
18 to administration of the Medicare prescrip-  
19 tion drug benefit).

20 “(ii) PAYMENTS FOR HIT BONUSES.—  
21 Payments under section 1903(a)(3)(F) (re-  
22 lating to payments to encourage the adop-  
23 tion and use of certified EHR technology).

24 “(iii) PAYMENTS FOR DESIGN, DEVEL-  
25 OPMENT, AND INSTALLATION OF MMIS AND

1 ELIGIBILITY SYSTEMS.—Payments under  
2 subparagraphs (A)(i) and (H)(i) of section  
3 1903(a)(3) for expenditures for design, de-  
4 velopment, and installation of the Medicaid  
5 management information systems and  
6 mechanized verification and information  
7 retrieval systems (related to eligibility).

8 “(5) PAYMENT OF AMOUNTS.—

9 “(A) IN GENERAL.—Except as the Sec-  
10 retary may otherwise provide, amounts shall be  
11 payable to a State under subsection (a) in the  
12 same manner as amounts are payable under  
13 subsection (d) of section 1903 to a State under  
14 subsection (a) of such section.

15 “(B) INFORMATION AND FORMS.—

16 “(i) SUBMISSION.—As a condition of  
17 receiving payment under subsection (a), a  
18 State shall submit such information, in  
19 such form, and manner, as the Secretary  
20 shall specify, including information nec-  
21 essary to make the computations under  
22 subsections (c)(2)(C) and (e).

23 “(ii) UNIFORM REPORTING.—The  
24 Secretary shall develop such forms as may  
25 be needed to assure a system of uniform

1 reporting of such information across  
2 States.

3 “(C) REQUIRED REPORTING OF INFORMA-  
4 TION ON MEDICAL LOSS RATIOS FOR MANAGED  
5 CARE.—The information required to be reported  
6 under subparagraph (B)(i) shall include infor-  
7 mation on the medical loss ratio with respect to  
8 coverage provided under each Medicaid man-  
9 aged care plan with a contract with the State  
10 under section 1903(m) or 1932.

11 “(b) AGGREGATE BENEFICIARY-BASED AMOUNT.—

12 “(1) IN GENERAL.—The aggregate beneficiary-  
13 based amount specified in this subsection for a State  
14 for a quarter is equal to the sum of the products,  
15 for each of the categories of Medicaid beneficiaries  
16 specified in paragraph (2), of the following:

17 “(A) BENEFICIARY-BASED QUARTERLY  
18 AMOUNT.—The beneficiary-based quarterly  
19 amount for such category computed under sub-  
20 section (c) for such State for such quarter.

21 “(B) NUMBER OF INDIVIDUALS IN CAT-  
22 EGORY.—Subject to subsection (d), the average  
23 number of Medicaid beneficiaries enrolled in  
24 such category in the State in such quarter.

1           “(2) CATEGORIES.—The categories specified in  
2       this paragraph are the following:

3           “(A) ELDERLY.—A category of Medicaid  
4       beneficiaries who are 65 years of age or older.

5           “(B) BLIND OR DISABLED.—A category of  
6       Medicaid beneficiaries not described in subpara-  
7       graph (A) who are described in section  
8       1937(a)(2)(B)(ii).

9           “(C) CHILDREN.—A category of Medicaid  
10      beneficiaries not described in subparagraph (B)  
11      who are under 21 years of age.

12          “(D) OTHER ADULTS.—A category of any  
13      Medicaid beneficiaries who are not described in  
14      a previous subparagraph of this paragraph.

15      “(c) COMPUTATION OF PER BENEFICIARY, PER CAT-  
16      EGORY QUARTERLY AMOUNT.—

17          “(1) IN GENERAL.—For a State, for each cat-  
18      egory of beneficiary for a quarter—

19          “(A) FIRST REFORM YEAR.—For quarters  
20      in the first reform year (as defined in sub-  
21      section (k)(2)), the beneficiary-based quarterly  
22      amount is equal to  $\frac{1}{4}$  of the base average per  
23      beneficiary Federal payments for such State for  
24      such category determined under paragraph (2),

1 increased by a factor that reflects the sum of  
2 the following:

3 “(i) HISTORICAL MEDICAL CARE COM-  
4 PONENT OF CPI THROUGH PREVIOUS RE-  
5 FORM YEAR.—The percentage increase in  
6 the historical medical care component of  
7 the Consumer Price Index for all urban  
8 consumers (U.S. city average) from the  
9 midpoint of the base fiscal year (as defined  
10 in paragraph (6)) to the midpoint of the  
11 fiscal year preceding the first reform year.

12 “(ii) PROJECTED MEDICAL CARE COM-  
13 PONENT OF CPI FOR THE FIRST REFORM  
14 YEAR.—The percentage increase in the  
15 projected medical care component of the  
16 Consumer Price Index for all urban con-  
17 sumers (U.S. city average) from the mid-  
18 point of the previous fiscal year referred to  
19 in clause (i) to the midpoint of the first re-  
20 form year.

21 “(B) SECOND AND THIRD REFORM  
22 YEARS.—The beneficiary-based quarterly  
23 amount for a State for a category for quarters  
24 in the second reform year or the third reform  
25 year is equal to the beneficiary-based quarterly

1 amount under this paragraph for such State  
2 and category for the previous reform year in-  
3 creased by the per beneficiary percentage in-  
4 crease (as defined in subparagraph (E)) for  
5 such category and reform year.

6 “(C) FOURTH THROUGH TENTH REFORM  
7 YEARS.—The beneficiary-based quarterly  
8 amount for a State for a category for quarters  
9 in a reform year beginning with the fourth re-  
10 form year and ending with the tenth reform  
11 year is—

12 “(i) in the case of a State that is a  
13 high per beneficiary State or a low per  
14 beneficiary State (as defined in paragraph  
15 (4)(B)(iii)) for the category, the amount  
16 determined under clause (i) or (ii) of para-  
17 graph (4)(B) for such State, category, and  
18 reform year; or

19 “(ii) in the case of any other State,  
20 the beneficiary-based quarterly amount  
21 under this paragraph for such State and  
22 category for the previous reform year in-  
23 creased by the per beneficiary percentage  
24 increase for such category and reform  
25 year.



1           “(D) ELEVENTH REFORM YEAR AND SUB-  
 2           SEQUENT REFORM YEARS.—The beneficiary-  
 3           based quarterly amount for a State for a cat-  
 4           egory for quarters in a reform year beginning  
 5           with the eleventh reform year is equal to the  
 6           beneficiary-based quarterly amount under this  
 7           paragraph for such State and category for the  
 8           previous reform year increased by the per bene-  
 9           ficiary percentage increase for such category  
 10          and reform year.

11          “(E) ANNUAL PERCENTAGE INCREASE BE-  
 12          GINNING WITH SECOND REFORM YEAR.—For  
 13          purposes of this subsection, the term ‘per bene-  
 14          ficiary percentage increase’ means, for a reform  
 15          year, the sum of—

16               “(i) the projected percentage change  
 17               in nominal gross domestic product from  
 18               the midpoint of the previous reform year to  
 19               the midpoint of the reform year for which  
 20               the percentage increase is being applied;  
 21               and

22               “(ii) one percentage point.

23          “(2) BASE PER BENEFICIARY, PER CATEGORY  
 24          AMOUNT FOR EACH STATE.—

25          “(A) AVERAGE PER CATEGORY.—

1           “(i) IN GENERAL.—The Secretary  
2           shall determine, consistent with this para-  
3           graph and paragraph (3), a base per bene-  
4           ficiary, per category amount for each of  
5           the 50 States and the District of Columbia  
6           equal to the average amount, per Medicaid  
7           beneficiary, of Federal payments under  
8           this title, including payments attributable  
9           to disproportionate share hospital pay-  
10          ments under section 1923, for each of the  
11          categories of beneficiaries under subsection  
12          (b)(2) for the base fiscal year for each of  
13          the 50 States and the District of Colum-  
14          bia.

15          “(ii) BEST AVAILABLE DATA.—The  
16          determination under clause (i) shall ini-  
17          tially be estimated by the Secretary, based  
18          upon the best available data at the time  
19          the determination is made.

20          “(iii) UPDATES.—The determination  
21          under clause (i) shall be updated by the  
22          Secretary on an annual basis based upon  
23          improved data. The Secretary shall adjust  
24          the amounts under subsection (a)(1)(A) to

1 reflect changes in the amounts so deter-  
2 mined based on such updates.

3 “(B) EXCLUSION OF PASS-THROUGH PAY-  
4 MENTS.—In computing base per beneficiary,  
5 per category amounts under subparagraph  
6 (A)(i) the Secretary shall exclude payments de-  
7 scribed in subsection (a)(4).

8 “(C) STANDARDIZATION.—

9 “(i) IN GENERAL.—In computing each  
10 such amount, the Secretary shall stand-  
11 ardize the amount in order to remove the  
12 variation attributable to the following:

13 “(I) RISK FACTORS.—Such risk  
14 factors as age, health and disability  
15 status (including high cost medical  
16 conditions), gender, institutional sta-  
17 tus, and such other factors as the  
18 Secretary determines to be appro-  
19 priate, so as to ensure actuarial  
20 equivalence.

21 “(II) GEOGRAPHIC.—Variations  
22 in costs on a county-by-county basis.

23 “(ii) METHOD OF STANDARDIZA-  
24 TION.—

1                   “(I) CONSULTATION IN DEVEL-  
2                   OPMENT OF RISK STANDARDIZA-  
3                   TION.—In developing the methodology  
4                   for risk standardization for purposes  
5                   of clause (i)(I), the Secretary shall  
6                   consult with the Medicaid and CHIP  
7                   Payment and Access Commission, the  
8                   Medicare Payment Advisory Commis-  
9                   sion, and the National Association of  
10                  Medicaid Directors.

11                  “(II) METHOD FOR RISK STAND-  
12                  ARDIZATION.—In carrying out clause  
13                  (i)(I), the Secretary may apply the  
14                  hierarchal condition category method-  
15                  ology under section 1853(a)(1)(C). If  
16                  the Secretary uses such methodology,  
17                  the Secretary shall adjust the applica-  
18                  tion of such methodology to take into  
19                  account the differences in services  
20                  provided under this title compared to  
21                  title XVIII, such as the coverage of  
22                  long term care, pregnancy, and pedi-  
23                  atric services.

24                  “(III) METHOD FOR GEOGRAPHIC  
25                  STANDARDIZATION.—The Secretary

1 shall apply the standardization under  
2 clause (i)(II) in a manner similar to  
3 that applied under section  
4 1853(c)(4)(A)(iii).

5 “(iii) APPLICATION ON A NATIONAL,  
6 BUDGET NEUTRAL BASIS.—The standard-  
7 ization under clause (i) shall be designed  
8 and implemented on a uniform national  
9 basis and shall be budget neutral so as to  
10 not result in any aggregate change in pay-  
11 ments under subsection (a).

12 “(iv) RESPONSE TO NEW RISK.—Sub-  
13 ject to clause (iii), the Secretary may ad-  
14 just the standardization under clause (i) to  
15 respond promptly to new instances of com-  
16 municable diseases and other public health  
17 hazards.

18 “(v) REFERENCE TO APPLICATION OF  
19 RISK ADJUSTMENT.—For rules related to  
20 the application of risk adjustment to  
21 amounts under subsection (a)(1)(A), see  
22 subsection (e).

23 “(D) ADJUSTMENT FOR TEMPORARY FMAP  
24 INCREASES.—In computing each base per bene-  
25 ficiary, per category amounts under subpara-

graph (A)(i) the Secretary shall disregard portions of payments that are attributable to a temporary increase in the Federal matching rates, including those attributable to the following:

“(i) PPACA DISASTER FMAP.—Section 1905(aa).

“(ii) ARRA.—Section 5001 of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 1396d note).

“(iii) EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.—Section 614 of the Children’s Health Insurance Program Reauthorization Act of 2009 (42 U.S.C. 1396d note).

“(3) ALLOCATION OF NONMEDICAL ASSISTANCE PAYMENTS.—The Secretary shall establish rules for the allocation of payments under this title (other than those payments described in paragraph (1) or (5) of section 1903(a) and including such payments attributable to section 1923)—

“(A) among different categories of beneficiaries; and

1 “(B) between payments included under  
 2 subsection (a)(1) and payments described in  
 3 subsection (a)(4).

4 “(4) TRANSITION TO A CORRIDOR AROUND THE  
 5 NATIONAL AVERAGE.—

6 “(A) DETERMINATION OF NATIONAL AVER-  
 7 AGE BASE PER BENEFICIARY, PER CATEGORY  
 8 AMOUNT.—Subject to subparagraph (C), the  
 9 Secretary shall determine a national average  
 10 base per beneficiary, per category amount equal  
 11 to the average of the base per beneficiary, per  
 12 category amounts for each of the 50 States and  
 13 the District of Columbia determined under  
 14 paragraph (2), weighted by the average number  
 15 of beneficiaries in each such category and State  
 16 as determined by the Secretary consistent with  
 17 subsection (d) for the base fiscal year.

18 “(B) TRANSITION ADJUSTMENT.—

19 “(i) HIGH PER BENEFICIARY  
 20 STATES.—In the case of a high per bene-  
 21 ficiary State (as defined in clause (iii)(I))  
 22 for a category, the beneficiary-based quar-  
 23 terly amount for such State and category  
 24 for a quarter in a reform year (beginning  
 25 with the fourth reform year and ending

1 with the tenth reform year) is equal to the  
2 sum of—

3 “(I) the product of the State-spe-  
4 cific factor for such reform year (as  
5 defined in clause (iv)) and the bene-  
6 ficiary-based quarterly amount that  
7 would otherwise be determined under  
8 paragraph (1) for such State and cat-  
9 egory if the State were a State de-  
10 scribed in clause (ii) of paragraph  
11 (1)(C), instead of a State described in  
12 clause (i) of such paragraph; and

13 “(II) the product of 1 minus the  
14 State-specific factor for such reform  
15 year and the beneficiary-based quar-  
16 terly amount that would otherwise be  
17 determined under paragraph (1) for a  
18 State and category if the base per  
19 beneficiary, per category amount de-  
20 termined under paragraph (2) for the  
21 State and category were equal to 110  
22 percent of the national average base  
23 per beneficiary, per category amount  
24 determined under subparagraph (A)  
25 for such category.



1                   “(ii)     LOW     PER     BENEFICIARY  
2                   STATES.—In the case of a low per bene-  
3                   ficiary State (as defined in clause (iii)(II))  
4                   for a category, the beneficiary-based quar-  
5                   terly amount for such State and category  
6                   for a quarter in a reform year (beginning  
7                   with the fourth reform year and ending  
8                   with the tenth reform year) is equal to the  
9                   sum of—

10                   “(I) the product of the State-spe-  
11                   cific factor for such reform year and  
12                   the     beneficiary-based     quarterly  
13                   amount that would otherwise be deter-  
14                   mined under paragraph (1) for such  
15                   State and category if the State were  
16                   a State described in clause (ii) of  
17                   paragraph (1)(C), instead of a State  
18                   described in clause (i) of such para-  
19                   graph; and

20                   “(II) the product of 1 minus the  
21                   State-specific factor for such reform  
22                   year and the beneficiary-based quar-  
23                   terly amount that would otherwise be  
24                   determined under paragraph (1) for a  
25                   State and category if the base per

beneficiary, per category amount determined under paragraph (2) for the State and category were equal to 90 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

“(iii) HIGH AND LOW PER BENEFICIARY STATES DEFINED.—In this subparagraph:

“(I) HIGH PER BENEFICIARY STATE.—The term ‘high per beneficiary State’ means, with respect to a category, a State for which the base per beneficiary, per category amount determined under paragraph (2) for such category is greater than 110 percent of the national average base per beneficiary, per category amount determined under subparagraph (A) for such category.

“(II) LOW PER BENEFICIARY STATE.—The term ‘low per beneficiary State’ means, with respect to a category, a State for which the base

1 per beneficiary, per category amount  
 2 determined under paragraph (2) for  
 3 such category is less than 90 percent  
 4 of the national average base per bene-  
 5 ficiary, per category amount deter-  
 6 mined under subparagraph (A) for  
 7 such category.

8 “(iv) STATE-SPECIFIC FACTOR.—In  
 9 this subparagraph, the term ‘State-specific  
 10 factor’ means—

11 “(I) for the fourth reform year,  
 12  $\frac{7}{8}$ ; and

13 “(II) for a subsequent reform  
 14 year, the State-specific factor under  
 15 this clause for the previous reform  
 16 year minus  $\frac{1}{8}$ .

17 “(C) NO ADDITIONAL EXPENDITURES.—

18 “(i) DETERMINATION OF INCREASE IN  
 19 FEDERAL EXPENDITURES.—For each cat-  
 20 egory for each reform year (beginning with  
 21 the fourth reform year and ending with the  
 22 tenth reform year), the Secretary shall de-  
 23 termine whether the application of this  
 24 paragraph—

1                   “(I) to the category for the re-  
2                   form year will result in an aggregate  
3                   increase in the aggregate Federal ex-  
4                   penditures under subsection (a); and

5                   “(II) to all the categories for the  
6                   reform year will result in a net aggre-  
7                   gate increase in the aggregate Federal  
8                   expenditures under subsection (a).

9                   “(ii) ADJUSTMENT.—If the Secretary  
10                  determines under clause (i)(II) that the  
11                  application of this paragraph to all the cat-  
12                  egories for a reform year will result in a  
13                  net aggregate increase in the aggregate  
14                  Federal expenditures under subsection (a),  
15                  the Secretary shall reduce the national av-  
16                  erage base per beneficiary, per category  
17                  amount computed under subparagraph (A)  
18                  for each of the categories determined  
19                  under clause (i)(I) for which there will be  
20                  an aggregate increase in the aggregate  
21                  Federal expenditures under subsection (a)  
22                  by such uniform percentage as will ensure  
23                  that there is no net aggregate Federal ex-  
24                  penditure increase described in clause  
25                  (i)(II) for the reform year.

1           “(5) REPORTS ON PER BENEFICIARY RATES;  
2       APPEALS.—

3           “(A) REPORT TO STATES.—Not later than  
4       8 months after the date of the enactment of  
5       this section, the Secretary shall submit to each  
6       State the Secretary’s initial determination of—

7                   “(i) the base per beneficiary, per cat-  
8                   egory amounts under paragraph (2) for  
9                   such State; and

10                   “(ii) the national average base per  
11                   beneficiary, per category amounts under  
12                   paragraph (4)(A).

13           “(B) OPPORTUNITY TO APPEAL.—Not  
14       later than 3 months after the date a State re-  
15       ceives notice of the Secretary’s initial deter-  
16       mination of such base per beneficiary, per cat-  
17       egory amounts for such State under subpara-  
18       graph (A)(i), the State may file with the Sec-  
19       retary, in a form and manner specified by the  
20       Secretary, an appeal of such determination.

21           “(C) DETERMINATION ON APPEAL.—Not  
22       later than 3 months after receiving such an ap-  
23       peal, the Secretary shall make a final deter-  
24       mination on such amounts for such State. If no  
25       such appeal is received for a State, the Sec-

1           retary’s initial determination under subpara-  
2           graph (A)(i) shall become final.

3           “(6) BASE FISCAL YEAR DEFINED.—In this  
4           section, the term ‘base fiscal year’ means the latest  
5           fiscal year, ending before the date of the enactment  
6           of this section, for which the Secretary determines  
7           that adequate data are available to make the com-  
8           putations required under this subsection.

9           “(d) NOT COUNTING INDIVIDUALS TO ACCOUNT FOR  
10          EXCLUDED PAYMENTS.—Under rules specified by the  
11          Secretary, individuals shall not be counted as Medicaid  
12          beneficiaries for purposes of subsection (b)(1)(B) and sub-  
13          section (c)(2)(A) in proportion to the extent that such in-  
14          dividuals are receiving medical assistance for which pay-  
15          ments described under subsection (a)(4)(A) are made.

16          “(e) RISK ADJUSTMENT.—

17                 “(1) IN GENERAL.—The amount under sub-  
18                 section (a)(1)(A) shall be adjusted under this sub-  
19                 section in an appropriate manner, specified by the  
20                 Secretary and consistent with paragraph (2), to take  
21                 into account—

22                         “(A) the factors described in subsection  
23                         (c)(2)(C)(i)(I) within a category of bene-  
24                         ficiaries; and

1 “(B) variations in costs on a county-by-  
 2 county basis for medical assistance and admin-  
 3 istrative expenses.

4 “(2) METHOD OF ADJUSTMENT.—

5 “(A) IN GENERAL.—The adjustments  
 6 under paragraph (1) shall be made in a manner  
 7 similar to the manner in which similar adjust-  
 8 ments are made under subsection (c)(2)(C) and  
 9 consistent with the requirements of clause (iii)  
 10 of such subsection and subparagraph (B).

11 “(B) BIENNIAL UPDATE OF RISK ADJUST-  
 12 MENT METHODOLOGY.—In applying clause  
 13 (i)(I) of subsection (c)(2)(C) for purposes of  
 14 subparagraph (A), the Secretary shall, in con-  
 15 sultation with the entities described in clause  
 16 (ii)(I) of such subsection, update the risk ad-  
 17 justment methodology applied as appropriate  
 18 not less often than every 2 years.

19 “(f) CHRONIC CARE QUALITY BONUS PAYMENTS.—

20 “(1) DETERMINATION OF BONUS PAYMENTS.—

21 If the Secretary determines that, based on the re-  
 22 ports under paragraph (5), with respect to cat-  
 23 egories of chronic disease for which chronic care per-  
 24 formance targets had been established under para-  
 25 graph (3) for each category of Medicaid beneficiaries

1 specified under subsection (b)(2) such targets have  
2 been met by a State for a reform year, the Secretary  
3 shall make an additional payment to such State in  
4 the amount specified in paragraph (6) for each quar-  
5 ter in the succeeding reform year. Such payments  
6 shall be made in a manner specified by the Secretary  
7 and may only be used consistent with subsection  
8 (a)(3).

9 “(2) IDENTIFICATION OF CATEGORIES OF  
10 CHRONIC DISEASE.—The Secretary shall determine  
11 the categories of chronic disease for which bonus  
12 payments may be available under this subsection for  
13 each category of Medicaid beneficiaries.

14 “(3) ADOPTION OF QUALITY MEASUREMENT  
15 SYSTEM AND IDENTIFICATION OF PERFORMANCE  
16 TARGETS.—

17 “(A) SYSTEM AND DATA.—With respect to  
18 the categories of chronic disease under para-  
19 graph (2), the Secretary shall adopt a quality  
20 measurement system that uses data described  
21 in paragraph (4) and is similar to the Five-Star  
22 Quality Rating System used to indicate the per-  
23 formance of Medicare Advantage plans under  
24 part C of title XVIII.



1           “(B) TARGETS.—Using such system and  
2           data, the Secretary shall establish for each re-  
3           form year the chronic care performance targets  
4           for purposes of the payments under paragraph  
5           (1). Such performance targets shall be estab-  
6           lished in consultation with States, associations  
7           representing individuals with chronic illnesses,  
8           entities providing treatment to such individuals  
9           for such chronic illnesses, and other stake-  
10          holders, including the National Association of  
11          Medicaid Directors and the National Governors  
12          Association.

13          “(4) DATA TO BE USED.—The data to be used  
14          under paragraph (3) shall include—

15               “(A) data collected through methods such  
16               as—

17                       “(i) the ‘Healthcare Effectiveness  
18                       Data and Information Set’ (also known as  
19                       ‘HEDIS’) (or an appropriate successor  
20                       performance measurement tool);

21                       “(ii) the ‘Consumer Assessment of  
22                       Healthcare Providers and Systems’ (also  
23                       known as ‘CAHPS’) (or an appropriate  
24                       successor performance measurement tool);  
25                       and

1 “(iii) the ‘Health Outcomes Survey’  
2 (also known as ‘HOS’) (or an appropriate  
3 successor performance measurement tool);  
4 and  
5 “(B) other data collected by the State.

6 “(5) REPORTS.—

7 “(A) IN GENERAL.—Each State shall col-  
8 lect, analyze, and report to the Secretary, at a  
9 frequency and in a manner to be established by  
10 the Secretary, data described in paragraph (4)  
11 that permit the Secretary to monitor the State’s  
12 performance relative to the chronic care per-  
13 formance targets established under paragraph  
14 (3).

15 “(B) REVIEW AND VERIFICATION.—The  
16 Secretary may review the data collected by the  
17 State under subparagraph (A) to verify the  
18 State’s analysis of such data with respect to the  
19 performance targets under paragraph (3).

20 “(6) AMOUNT OF BONUS PAYMENTS.—

21 “(A) IN GENERAL.—Subject to subpara-  
22 graphs (B) and (C), with respect to each cat-  
23 egory of Medicaid beneficiaries, in the case of  
24 a State that the Secretary determines, based on  
25 the chronic care performance targets set under

1 paragraph (3) for a reform year for such cat-  
2 egory, performs—

3 “(i) in the top five States in such cat-  
4 egory, subject to subparagraph (C)(ii), the  
5 amount of the bonus for each quarter in  
6 the succeeding reform year shall be 10 per-  
7 cent of the payment amount otherwise paid  
8 to the State under subsection (a) for indi-  
9 viduals enrolled under the plan within such  
10 category;

11 “(ii) in the next five States in such  
12 category, subject to subparagraph (C)(ii),  
13 the amount of the bonus for each such  
14 quarter shall be 5 percent of the payment  
15 amount otherwise paid to the State under  
16 subsection (a) for individuals enrolled  
17 under the plan within such category;

18 “(iii) in the next five States in such  
19 category, subject to clauses (i) and (iii) of  
20 subparagraph (C), the amount of the  
21 bonus for each such quarter shall be 3 per-  
22 cent of the payment amount otherwise paid  
23 to the State under subsection (a) for indi-  
24 viduals enrolled under the plan within such  
25 category;

1 “(iv) in the next five States in such  
2 category, subject to clauses (i) and (iii) of  
3 subparagraph (C), the amount of the  
4 bonus for each such quarter shall be 2 per-  
5 cent of the payment amount otherwise paid  
6 to the State under subsection (a) for indi-  
7 viduals enrolled under the plan within such  
8 category; and

9 “(v) in the next five States in such  
10 category, subject to clauses (i) and (iii) of  
11 subparagraph (C), the amount of the  
12 bonus for each such quarter shall be 1 per-  
13 cent of the payment amount otherwise paid  
14 to the State under subsection (a) for indi-  
15 viduals enrolled under the plan within such  
16 category.

17 “(B) AGGREGATE ANNUAL LIMIT FOR  
18 EACH CATEGORY OF MEDICAID BENE-  
19 FICIARIES.—

20 “(i) IN GENERAL.—In no case may  
21 the aggregate amount of bonuses under  
22 this subsection for quarters in a reform  
23 year for a category of Medicaid bene-  
24 ficiaries exceed the limit specified in clause  
25 (ii) for the reform year.

1 “(ii) LIMIT.—The limit specified in  
2 this clause—

3 “(I) for the second reform year is  
4 equal to \$250,000,000; or

5 “(II) for a subsequent reform  
6 year is equal to the limit specified in  
7 this clause for the previous reform  
8 year increased by the per beneficiary  
9 percentage increase determined under  
10 paragraph (1)(E) of subsection (c).

11 “(C) LIMITATION AND PRORATION OF BO-  
12 NUSES BASED ON APPLICATION OF AGGREGATE  
13 LIMIT.—

14 “(i) NO BONUS FOR THIRD OR SUBSE-  
15 QUENT TIERS UNLESS AGGREGATE LIMIT  
16 NOT REACHED ON FIRST TWO TIERS.—No  
17 bonus shall be payable under clause (iii),  
18 (iv), or (v) of subparagraph (A) for a cat-  
19 egory of Medicaid beneficiaries for a quar-  
20 ter in a reform year unless the aggregate  
21 amount of bonuses under clauses (i) and  
22 (ii) of such subparagraph for such category  
23 and reform year is less than the limit spec-  
24 ified in subparagraph (B)(ii) for the re-  
25 form year.

1                   “(ii) PRORATION FOR FIRST TWO  
2                   TIERS.—If the aggregate amount of bo-  
3                   nuses under clauses (i) and (ii) of subpara-  
4                   graph (A) for a category of Medicaid bene-  
5                   ficiaries for quarters in a reform year ex-  
6                   ceeds the limit specified in subparagraph  
7                   (B)(ii) for the reform year, the amount of  
8                   each such bonus shall be prorated in a  
9                   manner so the aggregate amount of such  
10                  bonuses is equal to such limit.

11                  “(iii) PRORATION FOR NEXT THREE  
12                  TIERS.—If the aggregate amount of bo-  
13                  nuses under clauses (i) and (ii) of subpara-  
14                  graph (A) for a category of Medicaid bene-  
15                  ficiaries for quarters in a reform year is  
16                  less than the limit specified in subpara-  
17                  graph (B)(ii) for the reform year, but the  
18                  aggregate amount of bonuses under clauses  
19                  (i) through (v) of subparagraph (A) for the  
20                  category and such quarters in the reform  
21                  year exceeds the limit specified in subpara-  
22                  graph (B)(ii) for the reform year, the  
23                  amount of each bonus in clauses (iii), (iv),  
24                  and (v) of subparagraph (A) shall be pro-  
25                  rated in a manner so the aggregate

1 amount of all the bonuses under subpara-  
 2 graph (A) is equal to such limit.

3 “(g) STATE OPTION FOR RECEIVING MEDICARE PAY-  
 4 MENTS FOR FULL-BENEFIT DUAL ELIGIBLE INDIVID-  
 5 UALS.—

6 “(1) IN GENERAL.—Under this subsection a  
 7 State may elect for quarters beginning on or after  
 8 the implementation date in a reform year to receive  
 9 payment from the Secretary under paragraph (3).  
 10 As a condition of receiving such payment, the State  
 11 shall agree to provide to full-benefit dual eligible in-  
 12 dividuals eligible for medical assistance under the  
 13 State plan—

14 “(A) the medical assistance to which such  
 15 eligible individuals would otherwise be entitled  
 16 under this title; and

17 “(B) any items and services which such eli-  
 18 gible individuals would otherwise receive under  
 19 title XVIII.

20 “(2) PROVIDER PAYMENT REQUIREMENT.—

21 “(A) IN GENERAL.—A State electing the  
 22 option under this subsection shall provide pay-  
 23 ment to health care providers for the items and  
 24 services described under paragraph (1)(B) at a  
 25 rate that is not less than the rate at which pay-

ments would be made to such providers for such items and services under title XVIII.

“(B) FLEXIBILITY IN PAYMENT METHODS.—Nothing in subparagraph (A) shall be construed as preventing a State from using alternative payment methodologies (such as bundled payments or the use of accountable care organizations (as such term is used in section 1899)) for purposes of making payments to health care providers for items and services provided to dual eligible individuals in the State under the option under this subsection.

“(3) PAYMENTS TO STATES IN LIEU OF MEDICARE PAYMENTS.—With respect to a full-benefit dual eligible individual, in the case of a State that elects the option under paragraph (1) for quarters in a reform year—

“(A) the Secretary shall not make any payment under title XVIII for items and services furnished to such individual for such quarters; and

“(B) the Secretary shall pay to the State, in addition to the amounts paid to such State under subsection (a), the amount that the Secretary would, but for this subsection, otherwise



1           pay under title XVIII for items and services  
2           furnished to such an individual in such State  
3           for such quarters.

4           “(4) FULL-BENEFIT DUAL ELIGIBLE INDI-  
5       VIDUAL DEFINED.—In this subsection, the term  
6       ‘full-benefit dual eligible individual’ means an indi-  
7       vidual who meets the requirements of section  
8       1935(c)(6)(A)(ii).

9           “(h) AUDITS.—The Secretary shall conduct such au-  
10       dits on the number and classification of Medicaid bene-  
11       ficiaries under such subsections and expenditures under  
12       this section as may be necessary to ensure appropriate  
13       payments under this section.

14          “(i) TREATMENT OF WAIVERS.—

15               “(1) NO IMPACT ON CURRENT WAIVERS.—In  
16       the case of a waiver of requirements of this title pur-  
17       suant to section 1115 or other law that is in effect  
18       as of the date of the enactment of this section, noth-  
19       ing in this section shall be construed to affect such  
20       waiver for the period of the waiver as approved as  
21       of such date.

22               “(2) APPLICATION OF BUDGET NEUTRALITY TO  
23       SUBSEQUENT WAIVERS AND RENEWALS TAKING SEC-  
24       TION INTO ACCOUNT.—In the case of a waiver of re-  
25       quirements of this title pursuant to section 1115 or

1 other law that is approved or renewed after the date  
2 of the enactment of this section, to the extent that  
3 such approval or renewal is conditioned upon a dem-  
4 onstration of budget neutrality, budget neutrality  
5 shall be determined taking into account the applica-  
6 tion of this section.

7 “(j) REPORT TO CONGRESS.—Not later than Janu-  
8 ary 1 of the second reform year, the Secretary shall submit  
9 to Congress a report on the implementation of this section.

10 “(k) DEFINITIONS.—In this section:

11 “(1) IMPLEMENTATION DATE.—The term ‘im-  
12 plementation date’ means—

13 “(A) July 1, 2022, if this section is en-  
14 acted on or before July 1, 2021; or

15 “(B) July 1, 2022, if this section is en-  
16 acted after July 1, 2021.

17 “(2) REFORM YEARS.—

18 “(A) The term ‘reform year’ means a fiscal  
19 year beginning with the first reform year.

20 “(B) The term ‘first reform year’ means  
21 the fiscal year in which the implementation date  
22 occurs.

23 “(C) The terms ‘second’, ‘third’, and suc-  
24 cessive similar terms mean, with respect to a  
25 reform year, the second, third, or successive re-

1 form year, respectively, succeeding the first re-  
 2 form year.”.

3 (b) CONFORMING AMENDMENTS.—

4 (1) CONTINUED APPLICATION OF CLAWBACK  
 5 PROVISIONS.—

6 (A) CONTINUED APPLICATION.—Sub-  
 7 sections (a) and (c)(1)(C) of section 1935 of  
 8 such Act (42 U.S.C. 1396u–5) are each amend-  
 9 ed by inserting “or 1903A(a)” after “1903(a)”.

10 (B) TECHNICAL AMENDMENT.—Section  
 11 1935(d)(1) of the Social Security Act (42  
 12 U.S.C. 1396u–5(d)(1)) is amended by inserting  
 13 “except as provided in section 1903A(g)” after  
 14 “any other provision of this title”.

15 (2) PAYMENT RULES UNDER SECTION 1903.—

16 (A) Section 1903(a) of the Social Security  
 17 Act (42 U.S.C. 1396b(a)) is amended, in the  
 18 matter before paragraph (1), by inserting “and  
 19 section 1903A” after “except as otherwise pro-  
 20 vided in this section”.

21 (B) Section 1903(d) of such Act (42  
 22 U.S.C. 1396b(d)) is amended—

23 (i) in paragraph (1), by inserting  
 24 “and under section 1903A” after “sub-  
 25 sections (a) and (b)”;

1 (ii) in paragraph (2)—

2 (I) in subparagraph (A), by in-  
3 serting “or section 1903A” after “was  
4 made under this section”; and

5 (II) in subparagraph (B), by in-  
6 serting “or section 1903A” after  
7 “under subsection (a)”; and

8 (iii) in paragraph (4)—

9 (I) by striking “under this sub-  
10 section” and inserting “, with respect  
11 to this section or section 1903A,  
12 under this subsection”; and

13 (II) by striking “under this sec-  
14 tion” and inserting “under the respec-  
15 tive section”; and

16 (iv) in paragraph (5), by inserting “or  
17 section 1903A” after “overpayment under  
18 this section”.

19 (3) CONFORMING WAIVER AUTHORITY.—Section  
20 1115(a)(2)(A) of the Social Security Act (42 U.S.C.  
21 1315(a)(2)(A)) is amended by striking “or 1903”  
22 and inserting “1903, or 1903A”.

23 (4) REPORT ON ADDITIONAL CONFORMING  
24 AMENDMENTS NEEDED.—Not later than 6 months  
25 after the date of the enactment of this Act, the Sec-

1       retary of Health and Human Services shall submit  
2       to Congress a report that includes a description of  
3       any additional technical and conforming amend-  
4       ments to law that are required to properly carry out  
5       this Act.

6       **TITLE    V—INCREASING    PRICE**  
7       **TRANSPARENCY   AND   FREE-**  
8       **DOM OF PRACTICE**

9       **SEC. 501. PUBLISHING OF CASH PRICE FOR CARE PAID**  
10       **THROUGH HEALTH SAVINGS ACCOUNTS.**

11       (a) HEALTH SAVINGS ACCOUNTS.—Section 223(f) of  
12       the Internal Revenue Code of 1986 is amended by adding  
13       at the end the following new paragraph:

14               “(9) CASH PRICE TRANSPARENCY REQUIRED  
15       FOR PAYMENTS TO HEALTH CARE PROVIDERS.—

16               “(A) IN GENERAL.—A payment to a health  
17       care provider with respect to the furnishing of  
18       health care items and services by such provider  
19       shall not be treated as a qualified medical ex-  
20       pense unless health care provider provides for  
21       continuing disclosure (such as through posting  
22       on a publicly accessible website) of the cash  
23       price the health care provider charges for the  
24       furnishing of such items and services.

1           “(B) FORM OF DISCLOSURE.—The disclo-  
2           sure of prices under this subsection shall be in  
3           a form and manner specified by the Secretary  
4           of Health and Human Services, in consultation  
5           with the Secretary, and shall be designed—

6                   “(i) to establish a single price for re-  
7                   lated items and services in a manner simi-  
8                   lar to the manner in which pricing and  
9                   payment for such items and services is pro-  
10                  vided under the Medicare program under  
11                  title XVIII of the Social Security Act, and

12                   “(ii) to make it easy for consumers to  
13                   compare the prices for similar items and  
14                   services furnished by different providers.

15           “(C) FAILURE TO FURNISH SERVICES OR  
16           CHARGE IN EXCESS OF STATED PRICE.—A  
17           health care provider shall be treated as not  
18           meeting the requirement of subparagraph (A),  
19           in the case of items and services for which the  
20           provider is disclosing a cash price, if the pro-  
21           vider—

22                   “(i) refuses to furnish such items or  
23                   services at the price listed, or

1 “(ii) charges more than the price list-  
2 ed for the furnishing of the items and serv-  
3 ices.”.

4 (b) ROTH HSA.—Section 530A(c)(4) of such Code,  
5 as added by section 201(a) of this Act, is amended by add-  
6 ing at the end the following new subparagraph:

7 “(E) Section 223(f) (relating to cash price  
8 transparency required for payments to health  
9 care providers).”.

10 (c) ENFORCEMENT.—If the Secretary of Health and  
11 Human Services determines that a health care provider  
12 has not provided for continuing disclosure of the cash  
13 price of health care provider charges under section  
14 223(f)(9) of the Internal Revenue Code of 1986, the Sec-  
15 retary may instruct the Secretary of the Treasury that  
16 payments made to such provider shall be not treated, for  
17 purposes of section 223 of the Internal Revenue Code of  
18 1986, as an amount used for a qualified medical expense  
19 for a period of not to exceed 1 year.

20 (d) EFFECTIVE DATE.—The amendments made by  
21 this section shall apply to taxable years beginning after  
22 December 31, 2021.

1 **SEC. 502. LIBERATING THE LOCAL PRACTICE OF HEALTH**  
2 **CARE.**

3 (a) **WAIVING NATIONAL RESTRICTIONS ON PHYSI-**  
4 **CIAN-OWNED FACILITIES.**—Section 1877 of the Social Se-  
5 curity Act (42 U.S.C. 1395nn) is amended by adding at  
6 the end the following new subsection:

7 “(j) **WAIVER AUTHORITY.**—A physician or other enti-  
8 ty may apply to the Secretary to waive any provision of  
9 this section and the Secretary may waive such provision  
10 with respect to such physician or entity if the Secretary  
11 determines that such waiver would—

12 “(1) increase competition within the health care  
13 market;

14 “(2) reduce the costs of health care; and

15 “(3) increase the quality of health care.”.

16 (b) **REMOVING CERTAIN STATE AND LOCAL LICEN-**  
17 **SURE OR CERTIFICATION RESTRICTIONS.**—

18 (1) **APPLICATION FOR WAIVER OF RESTRIC-**  
19 **TIONS.**—An individual who is required to be licensed  
20 or certified by a State as a condition of furnishing  
21 items or services as a health care professional (as  
22 defined by the Secretary of Health and Human  
23 Services) may submit to the Secretary an application  
24 to waive any condition of such licensure or certifi-  
25 cation.



1           (2) STANDARD.—The Secretary may grant a  
2       waiver submitted under paragraph (1) if the Sec-  
3       retary determines such waiver would—

4                   (A) increase competition within the health  
5       care market;

6                   (B) reduce the costs of health care; and

7                   (C) increase the quality of health care.

8           (3) PREEMPTION.—In the case of a health care  
9       professional granted a waiver under paragraph (2),  
10      any requirement with respect to which such waiver  
11      is granted is preempted to the extent specified in  
12      such waiver.

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